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MODERN
HOSPITAL

VOLUME 53

SEPTEMBER 1939

NUMBER 3

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IN COMMENTING

upon the forthcoming Toronto conventions, *The Hospital*, official journal of the British Hospitals Association, asks why it is that thousands attend a conference in America while scarcely hundreds attend its counterpart in England. After considering various explanations, the editors conclude that hospital people in the New World are, perhaps, more alive to the benefits that can be gained from meetings, discussions and the general interchange of information and ideas. Without attempting to pass any judgment upon the situation in Great Britain, it is fair to point out that hospital administrators, trustees and department heads in the United States and Canada have learned that the regional and national meetings of hospital associations furnish an important and effective method of keeping abreast of the rapid changes that are taking place in hospital administration on this continent.

It is true, of course, that some programs offered at such meetings seem to be made up without much imagination or a very clear understanding of what is significant in present day events. There may occasionally be justified criticism that the same persons appear too often on convention platforms or that insufficient recognition is given to the abler women in the field.

These details, however, are relatively unimportant in face of the fact that the conventions do offer such a wealth of important and useful material. Our August issue presented the excellent program of the International Hospital Association. The issue now in your hands contains programs of the American Hospital Association, American College of Hospital Administrators, Protestant Hospital Association, National Association of Nurse Anesthetists, American Congress on Obstetrics and Gynecology and the hospital standardization conference of the American College of Surgeons.

CONTENTS

NEXT month we will present complete reports on the Toronto and Cleveland conventions. Prompt and discriminating reporting of events and personalities and generous illustrations will mark this special section of the issue.

THE series of articles on tuberculosis will feature next month a discussion of the need for routine x-rays of the chest. Considerable comment, most of it favorable, has greeted the material so far presented in this series.

WHAT are the administrative problems presented by a department of orthopedic surgery? Dr. G. Otis Whitecotton of Stanford University Hospitals, San Francisco, has prepared a thoughtful article on this subject for our October issue.

WHAT is it that converts an unwilling trustee into an enthusiastic supporter ready to go out and get the money that is needed for that new x-ray department? When you stop to analyze it, the matter is simple enough. Something must happen that gives the trustee a vivid personal interest in the x-ray department and in the people who are inadequately served because it is poorly equipped. Ways of arousing this personal interest are described next month by Robert M. Cunningham, public relations officer at Evanston Hospital.

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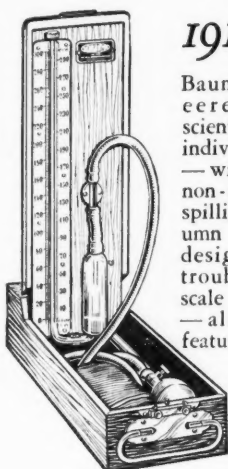
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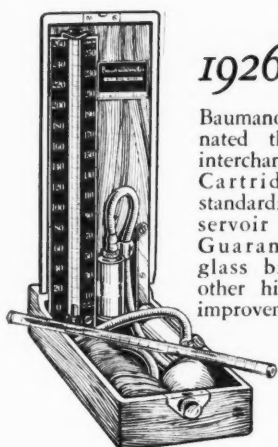
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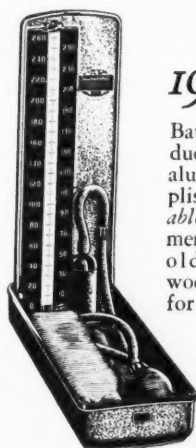
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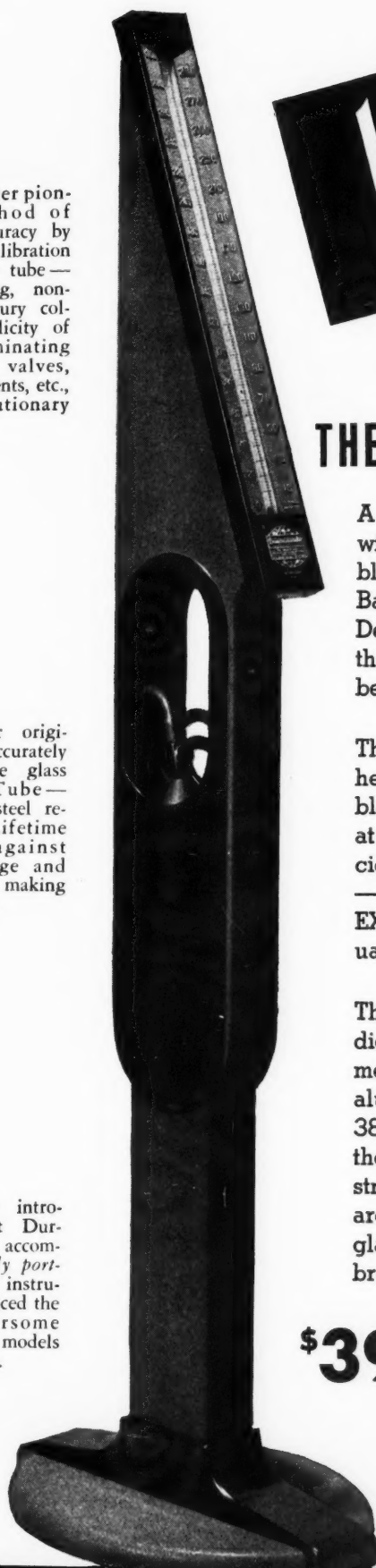
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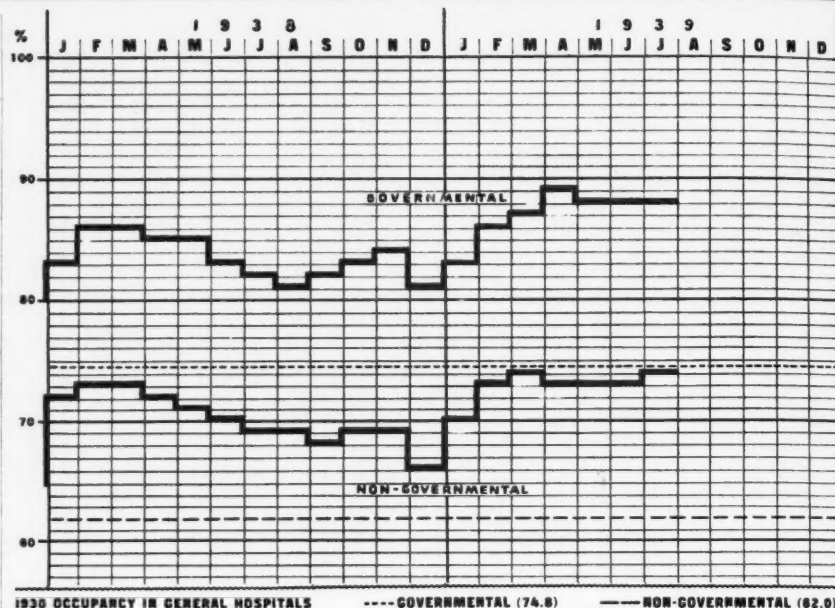
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HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data on Reporting Hospitals		1939		1938	
	Hosp. ¹	Beds ²	July	June	July	June
Government						
New York City.....	17	11,027	102*	102	95	99
New Jersey.....	5	2,236	89*	89*	91	88
Washington, D. C.....	1	1,220	70*	70*	70*	70*
N. and S. Carolina.....	19	2,102	72	72	71	72
New Orleans.....	2	2,466	114	112	96	96
San Francisco.....	3	2,255	93	90	87	87
St. Paul.....	1	850	70*	70*	64	66
Chicago.....	2	3,500	91	91	86	87
Total⁴.....	50	25,656	88*	87*	82*	83*
Nongovernment						
New York City.....	68	15,194	77*	77*	69	73*
New Jersey.....	62	9,938	73*	73*	67	68
Washington, D. C.....	9	1,818	72*	72*	72*	72*
N. and S. Carolina.....	104	7,103	69	69	65	66
New Orleans.....	7	1,176	79*	75*	76*	74
San Francisco.....	16	3,178	73	76	69	71
St. Paul.....	9	1,150	72*	72*	67	69
Chicago.....	14	2,433	64	69	63	64
Cleveland.....	7	1,074	84	80	74	76
Total⁴.....	296	43,064	74*	74*	69*	70*

¹Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. Excluding bassinets, usually. ²General hospitals only. ³Occupancy totals are unweighted averages. ⁴Preliminary report. Complete occupancy figures for January, 1933, to October, 1938, are given on page 798 of The Seventeenth Hospital Yearbook.



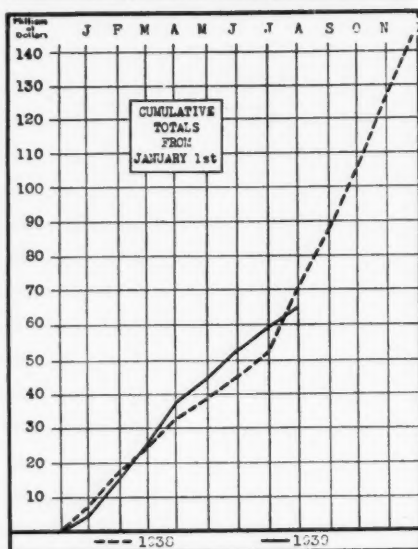
July Occupancy Figures Indicate Brisk Summer Activity

Occupancy in voluntary hospitals continued at a high level during July according to preliminary figures available at the time of going to press. The data show an occupancy of 74 per cent, which is substantially higher than has been recorded for any previous July during the last six years. Corrected figures may, of course, reduce this figure somewhat but apparently the activity in nongovernmental hospitals is continuing brisk.

In governmental general hospitals also occupancy continues at a high level this summer, the preliminary figures for July being boosted a point over those for June by an increased occupancy in New Orleans; other reporting cities remained at the same level. The only other time that an 88 per cent occupancy was recorded for these hospitals during the last six years was in 1934.

The number and value of new hospital building projects reported during the four weeks ending August 14 fell off somewhat from the average for the preceding months of the year. From the beginning of the year projects valued at \$64,942,000 have been reported, which may be compared with a total of \$70,884,000 for the same period last year. The recent four weeks period

HOSPITAL CONSTRUCTION



witnessed a total of 37 new projects of which 32 reported costs of \$5,802,431. There were 12 new hospitals of which 10 gave costs totalling \$2,761,000. Twenty-five additions to existing hospitals or allied institutions were reported of which 22 gave costs totalling \$3,041,431. No alterations or nurses' homes were listed during the period under review.

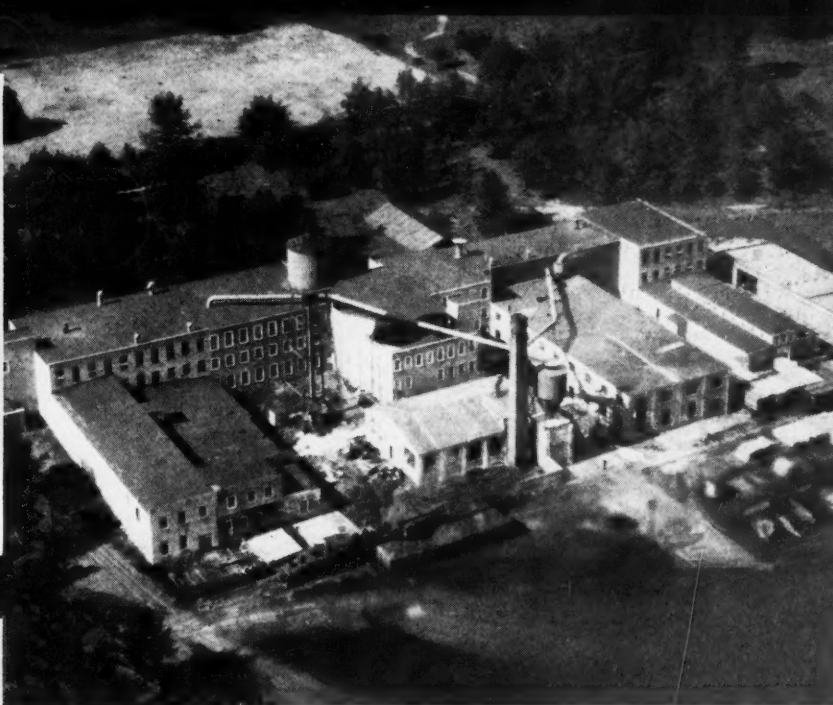
The general wholesale price index of the *New York Journal of Commerce* dropped during the period from July 15 to August 19 from 75.0 to 73.3. Grain, food, textile and fuel prices all fell in varying degrees, although the cost of building materials advanced somewhat. The biggest drop was in general food prices which went from 66.0 to 62.1 during the period. Fuel went from 84.1 to 80.5 and grain from 54.9 to 53.5. Building materials advanced from 95.8 to 96.4.

The price index for drugs and fine chemicals as tabulated by the *Oil, Paint and Drug Reporter* remained practically unchanged at 182.7.

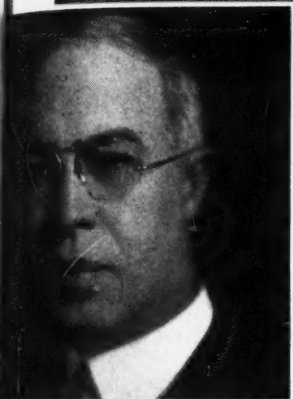
The number of unemployed was set at 9,552,000 in June, according to a survey released last month by the National Industrial Conference Board. This was a decline of 4.3 per cent from the previous month and of 11 per cent from February of this year. The June figure was stated to be the lowest since December 1937. Total employment in the country in June was estimated by the board at 45,028,000. The most important gain was in mining, followed by smaller gains in industry and agriculture. The government's emergency labor force was decreased by 25,000.



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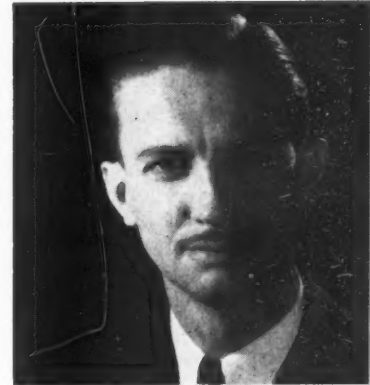
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WITH THE ROVING REPORTER

Thanks to the Ladies

• No hospital has more friends and staunch workers among its auxiliaries than the Children's Hospital in Los Angeles. It boasts seven auxiliaries whose members buy material, make garments and raise money to aid in the support of the Convalescent Home and other activities, all sponsored by local women.

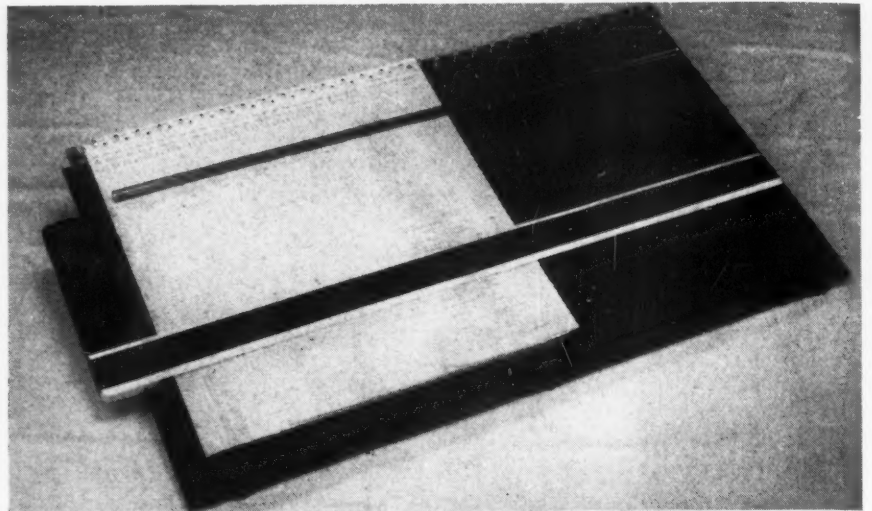
If you should happen along Maple Avenue one day and notice a store with "Dress Sale" advertised, it will quite possibly prove to be the Salvage Shop, a salesroom that is open every week day except Saturday for the benefit of the hospital. Last year it turned over \$8,914.77 toward the maintenance of the Convalescent Home, and for the last twenty years it has been earning money steadily from the sale of discarded articles. Incidentally, it is interesting to note that it will take everything; the supply of goods has never equaled the demand. Clothing—men's, women's and children's—is assured a quick turnover. Household goods, too, seldom fail to attract customers. The shop operates entirely with volunteers, the janitor being the only paid employee.

Then there is Las Maddinas, which for benefit of the uninitiated means "The Godmothers." This was organized in 1933 by 60 Los Angeles matrons to further the progress of the hospital, particularly the Convalescent Home. Each year on the second Friday evening of December is held the annual charity ball. Last year the sixth of the series produced \$4500 for the home.

Visit the hospital almost any morning and you will discover thoroughly trained young women taking the financial histories of patients, jotting down notes and acting as assistants in the 12 special clinics. Approximately 12 girls serve each day with a total of 10,572 hours of work. The kindergarten group, you are told, has 25 members who entertain and provide toys for the preschool age children in the hospital. Last year, they alone gave 1302 hours of service.

Those Women Drivers!

• Make no mistake, those cars that you see depositing patients at the entrance of the great Queens General Hospital in Jamaica, N. Y., do not belong to friends and relatives; not all of them, at least. They comprise the hospital motor corps, which is nothing more nor



Requests have been received for a photograph of the distribution board for controlling purchases and stores, described by Warren W. Irwin in his article, "Requisitions Control Stores," in the July issue of *The Modern Hospital*. In answer to these requests we are pleased to present it here.

less than a motor service for needy outpatients, provided by women who have cars and some spare time.

There is an interesting story behind it all. The motor corps was organized by Mrs. Hendrick Hendrickson, who for years has been active in social work. Soon after the hospital opened in 1935, Mrs. Hendrickson was called upon to help in getting to the hospital a patient who should have returned to the clinic for treatment following a serious abdominal operation but who was unable to do so because of having no way to make the trip. Mrs. Hendrickson agreed to serve as chauffeur. While waiting at the hospital to take the patient home, there was another urgent call. A patient ready to be discharged had no one at home who could bring her clothes to her. Again, Mrs. Hendrickson came to the rescue. Right then and there the motor corps idea was conceived.

Soon Mrs. Hendrickson had enlisted some of her friends who were glad to serve in this way. The names and addresses of patients to be transported were supplied by the social service department and the women divided the list. "We are not expected to be anything more than drivers," Mrs. Hendrickson explains. "The social service gives us the names of the patients and takes care of their problems. There is no expense other than gas and oil involved."

The amount of time the women devote to the work is optional. It may be one morning or afternoon each week or month, or it may be a part of every day. It is also their privilege to choose the communities from which they take patients, as well as the type of patient they wish to drive.

From the standpoint of the hospital, the service has proved invaluable. Particularly beneficial is it to those suffering from cancer, making it possible for many to come for radiation treatments who otherwise could not make the trip.

See Your Hospital First

• Lots of hospitals have conducted public tours of the institution. Recently we ran into a new twist for this idea.

Dr. John Gorrell of Blodgett Memorial Hospital, Grand Rapids, Mich., believes that if hospital tours are interesting and valuable to the public they can be just as interesting and even more valuable to members of the hospital's own staff. So Dr. Gorrell and his assistant, Ronald Yaw, are taking the entire personnel through the institution in groups of from four to eight at a time. The student nurses are scheduled for trips within two months of the opening of the term. It is surprising how many hospital employees are unfamiliar with some aspects of the institution's work.

The tour is carefully planned and in each department some interesting piece of equipment is actually demonstrated.

LOOKING FORWARD

Welcome, I. H. A.

TO ALL persons who have journeyed from afar to the Toronto convention of the International Hospital Association, greetings.

Hosts and guest alike, we are engrossed in a vital humanitarian task, one that transcends differences of language, race, creed or political and economic belief. Our lives devoted to the self-chosen duty of providing to those who are ill or injured or physically handicapped the finest care that the union of science and humanity can produce. To the generation that succeeds us we plan to pass on considerable knowledge beyond that brought down to us—medical knowledge and, through such gatherings as this, social understanding.

In their professional activities—care of the sick, teaching and research—the United States and Canada have much to take from the rich scientific storehouses of other countries. May delegates from over the seas find ideas here that will make the exchange fairly equal! To this international conference, The MODERN HOSPITAL joins all North America in welcoming you and adds the hope that this meeting will bring strong new social as well as scientific ties.

Bienvenida, I. H. A.

ATODAS las personas que han venido desde países lejanos a la convención en Toronto de la International Hospital Association, ¡saludos!

Anfitriones y huéspedes por igual, estamos embebidos en una tarea humanitaria vital, una tarea que propasa las diferencias de idioma, raza, credo u opinión política y económica. Nuestras vidas están dedicadas al deber que uno mismo ha escogido de proporcionar a aquellos que están enfermos o heridos o físicamente incapacitados el mejor cuidado que la unión de la ciencia y el sentimiento de humanidad puede producir. Nos hemos propuesto entregar a la próxima generación mayores conocimientos que los que nos han sido legados a nosotros—conocimientos médicos, y, por medio de reuniones como ésta, comprensión social.

En sus actividades profesionales—el cuidado del enfermo, la enseñanza y los trabajos de investigación—los Estados Unidos de América y el Canadá tienen

mucho que tomar de los ricos caudales científicos de otros países. ¡Ojalá que los delegados de países a través del mar, encuentren aquí ideas que les compensen igualmente por las que de ellos recibamos! The MODERN HOSPITAL se une a toda la América del Norte en darles la bienvenida a este conferencia internacional y tiene la esperanza de que de esta reunión resulten nuevos lazos fuertes, tanto sociales como científicos.

Benvenuti, I. H. A.

ATUTTI coloro che da lontani paesi vengono a partecipare alla Convenzione Internazionale Ospitaliera in Toronto, diamo il benvenuto.

Noi siamo per riunirci, con uno scopo vitale che trascende differenze di lingua, di razza, di religione e qualunque credo economico o politico. La nostra vita é dedicata, per nostra elezione, al dovere di provvedere, per coloro che sono sofferenti o fisicamente minorati, la migliore assistenza che gli sforzi riuniti della scienza e della pietá umana possono produrre.

Noi consideriamo di trasferire alle generazioni future una considerevole massa di nozioni nuove, oltre quelle a noi lasciate dalle passate generazioni. Nozioni scientifiche e, a traverso riunioni come la presente, migliore cooperazione sociale.

Gli Stati Uniti e il Canada hanno molto da apprendere dalle numerose ricerche scientifiche di altre nazioni, per lo sviluppo della loro attività professionale—assistenza degli ammalati, insegnamento professionale, ricerche scientifiche. Noi ci auguriamo che i delegati d'oltre mare trovino qui nuove nozioni, che parifichino lo scambio.

The MODERN HOSPITAL si unisce a tutta l'America del Nord, in augurarvi il benvenuto a questa conferenza internazionale, ed aggiunge la speranza che questa riunione risulti in una rinnovata solidarietà non solo scientifica, ma anche sociale.

Bienvenue, I. H. A.

NOUS avons l'honneur et le plaisir de souhaiter chaleureusement la bienvenue à tous ceux qui se sont donnés la peine de faire un long voyage pour venir à Toronto au Congrès de l'International Hospital Association.

Permettez Messieurs les Délégués et vous Messieurs les Invités, que nous vous rappelions ici, que notre but humanitaire englobe une tâche vitale qui ne connaît et ne fait aucune différence entre les langues parlées par les différents peuples, quelque soit la race à laquelle ils appartiennent, leur religion ou leur culte, leurs idées politiques ou économiques. Nous nous sommes donnés comme *modus vivendi*, le devoir d'apporter un soulagement à tous ceux affligés par les maladies ou, ceux dont les hazards de la vie ont placé dans un état d'incapacité corporelle, en leur prodiguant les soins les meilleurs, que l'union de la Science et de la Philanthropie a pu mettre à notre disposition. Nous avons le ferme désir de léguer à la génération qui nous succédera, des connaissances de beaucoup supérieures à celles qui nous ont été laissées en héritage—des connaissances médicales approfondies qui, jointes à une compréhension des devoirs vitaux, leur permettront d'être à la hauteur de leur tâche sociale.

Dans le cours des activités professionnelles — traitement des maladies, enseignement et recherches — les Etats Unis d'Amérique et le Canada n'hésitent pas à reconnaître qu'ils se pourvoient amplement des connaissances scientifiques que les pays étrangers mettent à leur disposition. Puissent les Délégués d'Outre-Mer faire ample provision des idées du Nouveau Monde de façon à établir une balance dans l'échange de documentation.

Les Editeurs et tous les collaborateurs de la revue *The MODERN HOSPITAL* s'associent de tout coeur à toute l'Amérique du Nord pour vous souhaiter, Messieurs les Délégués, la bienvenue au Congrès International et formule le voeu que cette conférence consolide d'avantage nos relations sociales pour permettre le développement dans un but commun, de nos idées scientifiques.

Willkommen, I. H. A.

WIR entbieten allen Personen, die von Fern und Nah zur Toronto-Tagung der International Hospital Association kamen, unsere herzlichen Grüsse.

Gäste und Gastgeber wirken vereint an einer grossen Aufgabe zum Wohle der Menschheit, an einer Aufgabe, die jeden Unterschied in Sprache, Rasse, politischer und wirtschaftlicher Weltanschauung ausgleicht. Unser Leben ist der selbstgewählten Aufgabe geweiht, allen jenen die krank, verletzt oder physisch benachteiligt sind die beste Sorgfalt angedeihen zu lassen, die derzeit das Zusammenwirken von Wissenschaft und Humanität bieten können. Wir wollen den kommenden Generationen ein besseres Wissen in medizinischen Fragen und besseres soziales Verstaendnis hinterlassen, als wir von unseren Vorgaengern uebernahmen.

Die USA und Kanada können viel aus den reichen wissenschaftlichen Erfahrungen des Auslandes auf den Gebieten der Krankenfürsorge, des Unterrichts und der

Forschung lernen. Möge das Ausland zum gerechten Ausgleich heifür Ideen und Anregungen von uns nach Hause mitnehmen. Anlässlich dieser Internationalen Konferenz begrüsst Sie *The MODERN HOSPITAL* zugleich in Namen des ganzen Nordamerika auf das herzlichste, in der Hoffnung, dass diese Tagung neue feste Banden in sozialer und wissenschaftlicher Hinsicht knüpfen möge.

Administrator's Library

THE great lack of books on hospital administration is rapidly being overcome. Ten years ago there was only a handful of worth while hospital texts. Today there are a score or more of good books available and nearly a dozen more in course of preparation.

Among the older books that should be found on every administrator's library shelves are: "Hospital Administration—A Career" by Michael M. Davis; "Hospital Organization and Operation" by Frank E. Chapman; "First Steps in Organizing a Hospital" by Joseph J. Weber; "Hospital Law" by Lapp and Ketcham; "Medical Administration of Teaching Hospitals" by Emmet B. Bay; "The Public's Investment in Hospitals" by C. Rufus Rorem; "Medicine and the State" by Sir Arthur Newsholme; the final report of the Commission on Medical Education, and "Medical Care for the American People," which contains the recommendations of the Committee on the Costs of Medical Care.

In the past few years the following important books have appeared: "Hospital Organization and Management" and "Medical Records in the Hospital" by Malcolm T. MacEachern; "Legal Aspects of Hospital Work" by Hayt and Hayt; "The Hospital Survey for New York" by Haven Emerson and his associates; "The Hospital Manual of Operation" by Warren P. Morrill; "The Medical Staff in the Hospital" by Thomas R. Ponton; "Nursing Schools—Today and Tomorrow" by the Committee on the Grading of Nursing Schools; "American Medicine—Expert Testimony Out of Court" by the American Foundation, and "Hospital Public Relations" by Alden B. Mills. Several good short monographs and technical books have also appeared on such subjects as accounting and nursing.

A group of hospital texts, now in course of preparation, should be available within the next year or so. Doctor MacEachern and Raymond P. Sloan are both preparing books on hospital trustees: Dr. Bert W. Caldwell is writing on hospital law. John E. Ransom has been at work for many years on his monumental book on hospital history. Arthur C. Bachmeyer is writing a general text on hospital administration and, in collaboration with Gerhard Hartman, is also preparing a book of readings in hospital administration. Dr. Robin C. Buerki is working on the final report of the Commission on Graduate Medical Education.

It is probably no accident that such a large number of books is now appearing in the hospital field. The development of institutes and of courses for training hospital administrators has made the field far more alert to educational opportunities. The American College of Hospital Administrators has stimulated all executives to consider more carefully their own training and preparation for their responsibilities. This educational awareness has created a demand for books that the publishers in the field are glad to meet.

In Purchasing Insurance

NO WELL-RUN hospital would think of buying a \$1500 x-ray machine without ascertaining through careful study whether the machine would actually fill its needs. Yet how many such hospitals still buy insurance without comparable analysis and comparison?

The problem of the hospital administrator and board of trustees in purchasing insurance is to secure themselves and their institution against loss. They should be interested, first of all, in obtaining complete and comprehensive coverage. They should then inquire about the service that can be rendered by their insurance agent and by the companies that this agent represents. Complete intelligent service is essential if the insurance program is to accomplish its purpose. Security of indemnity is both the primary and the final objective in the purchase of insurance, whether it is for public liability, fire or fidelity bonds. Hence, the ability and willingness of the company to make good on its obligations constitute an important third point.

The most important and least understood aspect of hospital liability insurance is the actual amount of protection obtained by the hospital. For example, in certain types of cases the injured party has no claim against the institution but may file a claim against the administrator as an individual. Is this possibility covered?

Does present insurance provide automatic protection of additions made to hospital equipment or must the company be notified in order to obtain this added protection?

Is the hospital's public liability policy limited to "bodily injuries accidentally suffered" or will it protect in all claims for which the hospital may become legally liable?

Does the policy provide protection against claims arising from injuries sustained off the hospital premises?

Is a complete engineering and accident prevention service furnished by the insurance company?

These are only a few of the questions that ought to be asked in an intelligent selection of hospital insurance. Price will always be emphasized by companies having nothing better to offer but it should be a

secondary consideration in the purchase of this protection. During recent years considerable progress in hospital insurance has been made until it is now possible to obtain a single policy covering all public liability risks.

Obstetrics in General Hospitals

A FEW years ago Dr. Joseph B. DeLee, Paul de Kruif and others were engaged in a violent attack upon all general hospitals that accepted maternity patients. The data they published appeared to indicate that maternal mortality was unduly high in such institutions. The inference was even drawn by some writers that the general hospitals were themselves largely responsible for the high maternal mortality in this country.

Undoubtedly there was a core of truth in the statements. Some general hospitals did accept women for delivery without having the proper physical facilities or staff organization to assure protection to these women from the infective hazards to be found in any general hospital. Looking back upon the developments of the last five years, we may now feel grateful to DeLee and his followers for their overstatements.

The criticism has resulted in tremendous improvements. In an article entitled, "An Obstetric Audit," which appeared in the *Journal of the American Medical Association* for July 29, Dr. Scott C. Runnels, secretary of the Hospital Obstetric Society of Ohio, reviews a mass of evidence on the present state of obstetric care. He concludes that obstetrics in the United States has been making decided and accelerated strides in the reduction of maternal mortality and that the hospitalization of women for delivery in well-run hospitals has played an important part in achieving this reduction. The puerperal death rate per thousand live births has fallen from 6.19 in 1933 to 4.89 in 1937, a reduction of 21 per cent in four years.

Doctor Runnels gives a substantial share of the credit for the improvement in obstetric practice to the increased percentage of deliveries in hospitals and to the growing sense of responsibility felt by hospitals for the character of work being done within their walls.

The two most important safeguards, in Doctor Runnels' opinion, are: (1) that the hospital maintain proper obstetric regulations, especially isolation of the department, as outlined by the American Hospital Association, and (2) that the hospital have a proper staff organization, including a chief, with power to enforce consultation for all questionable conditions.

That there is still much ground to be gained is indicated by Doctor Runnels' final statement that "if obstetric conditions were as favorable over the entire United States as are those existing today in a quarter of the country, there would be an annual saving of 2500 lives."

ROBERT N. BROUGH

How We Filled



The new wing that "would never be filled" will have to be enlarged.

TEN years ago the Norwalk General Hospital opened enlarged facilities generously provided by its principal benefactor, E. T. Bedford. About three quarters of a million dollars had been spent to increase the number of beds from 90 to 180 and to modernize equipment in all departments.

These changes had evoked misgivings by some, who characterized the enlarged building as "a white elephant." The prediction was rife that the new wing would never be filled. Four depression years lent color to the theory. The number of patients remained practically stationary, averaging 90 in 1930, the first year in the new quarters, and 91 in 1933. The per capita cost per week was \$37.95 in 1928 in the old quarters (1929 being a year of transition) and 29 per cent higher, or \$48.89, in 1930 in the new.

As the miasma of business inertia spread, this figure slowly retreated, but the operating deficit grew as the revenue from patients fell faster than did the cost of maintenance. During this period the financial problem was severe and unending, as creditors clamored for payment of bills long past due. Drastic measures were in-

dicated, but were rejected as being harmful in the long run. In a factory town without much wealth reduced charges to patients were indicated. Donations had fallen to a low ebb, and could not be stimulated. Therefore, increased revenue per unit of service could not be anticipated.

Slowly a pathway out of the wilderness was found. A thorough survey by Charles F. Neergaard, New York, who is a leading hospital consultant, made many recommendations looking toward efficiency, economies, increased revenue and public good will. These ranged through practically all departments or activities. Prompt and energetic adoption of most of the recommendations led to a change in the tide. In 1934 the revenue from patients increased 19 per cent while the expenses were slightly decreased. As a result, the annual operating deficit shrank from \$72,572 to \$46,142.

Thus did a new day dawn, together with a determination to fill the building to capacity by making the hospital so popular with the area served that an expansion program would be necessary before many years. This seemed to be logical because authorities claimed that some hospitals in similar suburban or semirural areas filled about three

beds per thousand of population served. The Norwalk area in 1934 embraced about 55,000 people and, accordingly, should have had about 150 patients (allowance being made for a few who inevitably are directed to New York and New Haven for specialized treatment). Gradually the foundation was laid for such an objective.

A program was adopted in harmony with the principles of sound administrative hospital management as outlined by the American Hospital Association. This included:

1. The formation of a tumor clinic to fill a gap in the community's health services.

2. Improvement of the approach to the hospital, giving it an admirable situation on a hill overlooking the two main business sections.

3. The formation of a local hospital service plan, serving Norwalk and the vicinity, which has been particularly successful. In three years about 20,000 members have been enrolled, nearly 75 per cent locally, or 15,000 out of a population served of approximately 55,000 people.

4. A steady, carefully prepared publicity program intended to mirror properly the hospital's activities and policies to the public.

5. Careful education and training of employes in policies, methods and technics so that the motto of "Courtesy — Service — Thoughtfulness" might become vital rather than academic. The "Hospital Guide," a printed manual of 85 pages issued to all doctors, interns, nurses and employes, was invaluable in this respect. Its pages contained the essence of instructions on hundreds of points which had stood the test of time; it breathed a constant determination to approach both patients and public with the attitude, "Can We Help You?" and to render "Service With Human Understanding"; it fostered esprit de corps among employes to a marked degree. Those who could or would not follow the new standards were tactfully eliminated.

6. Improvement of physical facilities as needed. In the five years from

The author is superintendent of Norwalk General Hospital, Norwalk, Conn.

an Empty Wing

1934 to 1938, \$107,920 was spent for new equipment, a new boiler room and the purchase of two annexes to the school of nursing building. These additional buildings became necessary because, until 1937, some of the graduate nurses were housed within the main building, withdrawing 15 beds from patient use. When these were restored to their proper purpose additional housing accommodations for nurses became necessary.

7. Enlargement of the school of nursing. For years the school of nursing had been maintained with a question mark hanging over its head. Enrollment fluctuated between 35 to 40 students whose nursing services were supplemented with 20 graduates. The superintendent of nurses at that time half believed that the school of nursing should be closed. In 1937 a new principal of the school converted a liability into an asset. Now the school has 60 enthusiastic students, who do much to make the school and the hospital popular. Three annexes to the school of nursing building have been purchased, renovated and altered, exactly doubling the housing accommodations for nurses. Ninety nurses are now most comfortably housed. The hospital now owns 14 acres of nicely parked land which it hopes will gradually be converted into a medical center.

It is difficult to evaluate the relative importance of the component parts of this program, though the service plan stands out as having done more than anything else to create good will. When it was in process of formation in 1935, efforts were made to launch a plan for Fairfield County, embracing six hospitals, but for good reasons a negative response was made to the suggestion.

Despite misgivings concerning the wisdom of a hospital launching a service plan in a city of less than 40,000 population, the results have been most satisfactory in every respect. The good will created by providing such an easy method of paying hospital bills at \$9 annually, or less, has been widespread and incal-

culable. No finer move could have been made to create friends.

The publicity program also is worthy of special mention. Not only has splendid cooperation by the local press been obtained, under which frequent news releases are published in full as issued, but in various other ways have the activities been well presented to the public. The annual reports have been prepared with unusual care as pamphlets telling a well illustrated story, rather than as dry, official compilations of verbose reports in which "everyone from the president down to the office boy



Around the Hospital: Above: An accident victim gets first aid. Top Right: A corner of the laboratory. Lower Right: A patient receives a plant. Below: It's time to eat again.



thanks each other in endless repetition for aid in a job well done."

Special booklets carefully prepared with the aid of advertising counsel were issued from time to time. "The Norwalk Hospital Speaks" and "To You, Who Are My Friend" were particularly valuable. They were publications of a high type, broadcasting the message of "A Modern Wayside Inn on the Road to Health," a place of peace and quiet where

Table 1—Survey Recommendations

Recommendations	Annual Saving	Action Taken
<i>Improved Collections Methods</i>		Adopted
Patients' booklet of information and schedule of charges		Now in use
<i>Reduction in Expenses</i>		
Dietary department	\$2,500	Adopted
Payroll adjustments	4,500	Adopted
Elimination of allowances to students		Effective with Sept. 1933 class pymts. to other students will cease as they are graduated
Reduction in number of graduate nurses		No progress made. Twenty-three graduates now on payroll; 21 graduates on payroll at time of survey
Reduction in insurance expense		Appraisal of property made. Recommendation not approved for corporate reasons
Budgetary control of expenses		In effect
Economies in the purchase and use of supplies	5,500	Adopted
Consolidation of children's accommodations		Partially in effect
Control of goods and supplies		System in effect with slight modification
<i>Increasing Earnings</i>		
Base rate for private ward patients		No action taken. Recommendation opposed by staff
Modification of charges		Now in effect
Increased use of laboratory by staff for referred private work		Affirmative action taken.
<i>Charges to Patients</i>		
Adjustment of room rates		In effect
Revised schedule of x-ray charges		In effect
Appointments of a joint committee representing the board of trustees and the professional staff to foster increased use of diagnostic and therapeutic departments		No action taken
Routine laboratory charges		In effect
Use of flat rates		In effect
<i>Dietary Department</i>		
All recommendations		In effect
<i>Laundry</i>		
System of laundry control		In effect
<i>Nursing Department</i>		
Closing one out of four operating rooms		No action taken
Special duty nurses to pay registration fee to hospital		No action taken
Night duty for student nurses		In effect
Obtaining New York State registration		No action taken
Study of effect of closing school of nursing		Recommendation not approved
<i>Administrative Matters</i>		
Instituting suits in small claims court		Now in effect
Analysis of charity cases to determine need of social service financial investigator		Necessary financial investigation now done by office force
<i>Corporation Matters</i>		
Increasing number of directors from twelve to eighteen or twenty-four		Board increased December 1933
Revising and enlarging personnel of executive committee		Committee increased December 1933
Appointing other committees of board of directors		Committees appointed February 1934

Table 2—Comparative Occupancy in 1933 and 1938

	1933	1938	Per Cent Increase
Patients admitted.....	3,047	4,885	60
Other patients treated.....	1,335	2,225	67
Days' care.....	33,105	52,095	57
Average daily census.....	91	143	57
Operations.....	1,223	2,122	74
Births.....	471	718	53

Table 3—Comparative Financial Statistics for Five Years Ending 1933 and 1938

	Five Years Ending 1933	Five Years Ending 1938	Increase
Net revenue from patients.....	\$ 759,891.11	\$1,022,309.99	\$262,418.88
Operating expenses.....	1,049,418.21	1,195,524.16	146,105.95
Operating deficit—(covered by donations and endowment fund income).....	\$ 289,527.10	\$ 173,214.17	\$126,312.93 (dec.)

the sick and injured may tarry while devoted professional men and women work day and night for their speedy restoration and recovery."

Sustaining and buttressing specific measures was a determination to do an unusually good job, to render satisfaction at all costs. The principle was adopted that the public is right, that at least 97 per cent of the people try to treat hospitals fairly. Care was taken to adjust charges to the pocketbook rather than to price schedules. Complaints (and there are complaints concerning well-managed hospitals) were carefully and promptly investigated and care was taken to "admit the corn" unless the hospital's case was beyond just criticism. This did not involve disloyalty to a hard-working organization, rather the use of good business psychology.

And what were the results? The tables best tell the story.

Such things don't just happen. They are produced by real work and a determination to reach the goal. There were many obstacles, including misunderstandings, differences of opinion within the organization, indifference and most of the other headaches that are encountered when a difficult task is undertaken. But the steady progress made during the five years was usually a sufficient tonic to dispel brief periods of discouragement. Now as one looks back over the road that has been traveled there seems to have been no real cause for cessation of endeavor.

During 1939 to date, the average number of patients has been 160 (with a peak of 194 on one day), or 88 per cent of capacity. The maternity floor, in particular, has been occupied to 130 per cent of capacity. Therefore, plans are being drawn for a separate maternity unit or "home for mother and child," which will be constructed as soon as funds can be obtained. Other departments will be enlarged at the same time, to provide a balanced hospital. In short, the determination to please the patient and public has produced fruits much more quickly than was expected; an indefinite plan became a successful five year plan. So wholeheartedly has the public accepted "service plus" that physical resources appear to shrink steadily, while old standards are discarded and replaced by better standards.

Modernizing St. Clare's

ROBERT J. REILEY

THE fastest depreciation in a building takes place in the mechanical equipment. The bathrooms begin to look antiquated and the radiators become eyesores long before the structure shows signs of deterioration. A hospital has proportionally more mechanical equipment than any other class of building; hence it becomes outmoded more quickly than other types of construction.

A hospital building is subject to rapid obsolescence for a second reason. The constant improvement that is made in methods and techniques for the care and treatment of the sick calls for changes in the arrangement of rooms and in the allocation of space to house new equipment. In many cases this new equipment must be supplied and connected with electric current, water or steam; in old buildings these services are generally found to be taxed to the limit. In consequence, radical steps must be taken, which not infrequently mean that the old mechanical plant has practically to be scrapped.

Service Departments Grow

The demand for space for uses other than beds has grown rapidly. Today the x-ray department, the laboratories, the physical and hydrotherapy departments, the basal metabolism room and the preparation and filing of case records require amounts of space unheard of a few years ago. In consequence, the well-designed hospital of today has a smaller proportion of space devoted to beds than was formerly the case. This is unfortunate from a financial point of view, but it seems unavoidable.

When an architect is called in to prepare sketches for modernizing a hospital it may, therefore, develop that, if no more space is added, the result will be an up-to-date institution prepared to give the best of service but with fewer beds. Such a

The new building is sandwiched in between the original hospital, which is shown at the extreme right, and another unidentified building.



suggestion is received with consternation by the trustees. Instead of decreasing the bed space, more is almost invariably required because of the increasing use of hospitals by the public.

Looking ahead there is every reason to believe that hospital beds will be in still greater demand because of hospital care insurance plans, the great health programs being planned and also the changing attitude of the less educated section of the public toward hospitals. All of these factors will generally mean that an attempt to modernize a hospital will result in the decision to build another wing or perhaps add another story on to the existing building. In other words, modernization generally involves increasing the capacity of the institution rather than merely remodeling it.

St. Clare's Hospital in West Fifty-First Street, New York City, is a good example of this procedure. A hospital building was erected 38 years ago on a plot of ground 50 by 100 feet, between other structures; after many years of use it was abandoned as a hospital. The institution

was reopened four years ago by the Franciscan Sisters of Allegany, N. Y., under the name of St. Clare's Hospital. It soon became popular, especially with middle-class people living on the west side of the city. The maternity department, in particular, was well patronized and spread out so that it occupied far more space than was originally allowed for it. The total capacity was 80 beds, but the demand for accommodations greatly exceeded this figure.

The trustees, feeling that something must be done, discussed the needs of the hospital with the Catholic Charities of the Archdiocese of New York and it was decided to modernize and increase the capacity by 60 beds. An adjoining plot of ground was acquired. No change could be made in the old building until the addition was completed, since every foot of space was being used to the maximum. The plans were prepared with the idea that after the addition was in use the old building would be remodeled so that eventually the old and new together would form a modern hospital that was up to date in every detail.

Mr. Reiley is a New York architect.



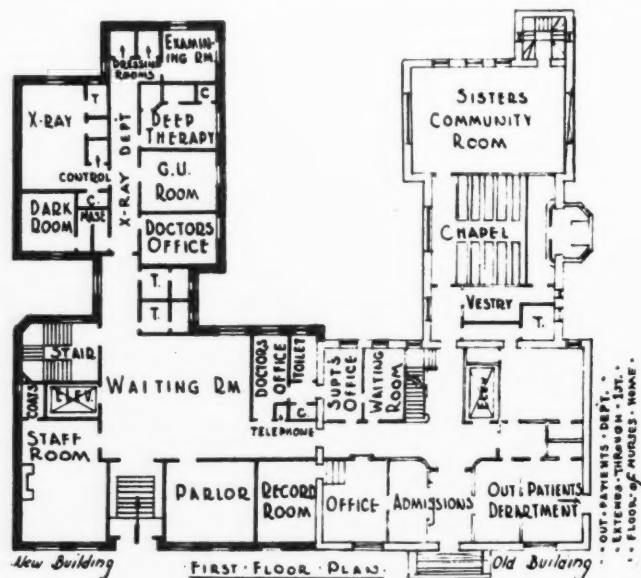
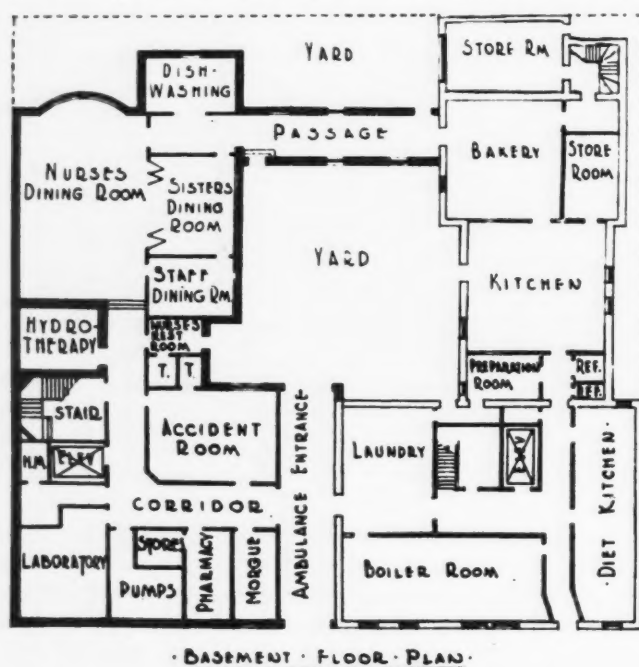
A view from the sun deck showing the city's skyscrapers in the distance.

The accompanying floor plans show how this was accomplished; the old building on the right is indicated by the shaded lines and the new structure, in solid black. Economy was kept in mind and the results accomplished have been made possible through the cooperation of Mother Alice, the Superior, whose intimate knowledge of the operation of a hospital and whose years of experience as a superintendent made it possible to attain unusually good results.

One of the first problems met was the fact that the main floor of the

old building was many steps above the street level, which was a decided disadvantage. It was felt that for ease in communication the floors in

Right: The first floor of the new building is level with the old. The out-patient department extends through to the adjoining home for student nurses.



Left: The plan of the basement, in which are located the kitchen, dining rooms, laboratory, pharmacy and the hydrotherapy departments.

both buildings should be on the same level. Therefore, an entrance was arranged so that private cars and ambulances are driven down a ramp into the courtyard where on the basement floor the patients may take the elevator without encountering any steps. At the new entrance the steps to the main floor have been placed inside rather than outside the vestibule, as was done in the old building, and all the floors run on the same level in both buildings.

When the new building was completed, the x-ray department was the first to be put into service, and entirely new equipment of the latest type was acquired for it. The space on the first floor of the old building formerly occupied by this department, as well as the first floor of the adjoining nurses' home, was refitted for the use of the newly organized out-patient department. Although the entire space assigned to it is small, it is hoped that by careful assignment of hours a great neighborhood need will be served. The

new x-ray department is also on the first floor so that it will be convenient to the out-patient department.

New dining rooms have been provided for Sisters, nurses and the staff, and the kitchen has been given larger quarters by adding to it the space of the dining room formerly used by the Sisters.

The building of the addition provided the opportunity to supply much needed private rooms. These rooms are cheerful and homelike. Each has its own toilet room with

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Forestalling Tuberculosis

WILLIAM OGDEN, M.D.,

The scene is in a doctor's office in the year 1939. The doctor and a young man patient are seated on either side of the desk.

PATIENT: Why are you watching me for possible tuberculosis when my contact with the disease was broken twelve months ago? My chum who has tuberculosis has been in sanatorium for a year.

DOCTOR: Because tuberculosis develops subsequently in some 25 per cent of all those intimately exposed and only under exceptional circumstances within the first year. Indeed the average length of time it takes in the adult for the disease to develop seems to be four or five years after such exposure. Sometimes it takes ten years or longer.

PATIENT: Then I may still get tuberculosis?

DOCTOR: Yes, but not if you get enough rest and sufficient food at well-balanced meals. None of our contacts who took this simple advice got tuberculosis.

PATIENT: How do you know that I have been actually infected with tuberculosis germs?

DOCTOR: Because your tuberculin skin test tells us that by its pink reaction.

PATIENT: Why not wait until I am ailing, tired, losing weight or coughing?

DOCTOR: Too late! That has been the procedure up till now. There are reasons why that method is not good enough today. You see when your tuberculin test became positive, it indicated that contact with your friend, now in sanatorium, resulted in your becoming infected, but you were not suffering from the disease tuberculosis. If, some years later, symptoms appear and you have waited for these before reporting for examination, at that time your x-ray may show certain abnormal shadows or your sputum may contain the

germs of tuberculosis; disease then will have occurred; efforts at prevention will have failed.

Because in early disease, symptoms are frequently absent or slight, your disease already may have become extensive. The fact is that, until recently, there has been no known method of anticipating tuberculosis or of selecting from a group of infected contacts those who are in process of developing disease. It was even true that from the time a tuberculin test became positive until disease was demonstrable, we had no certain knowledge whether or not the tubercle bacilli were producing any effect in the body. Lack of that knowledge often resulted not only in failure to prevent tuberculous disease but also in unnecessarily late diagnosis. It is such late diagnosis that is largely responsible for the spread of tuberculosis and also for the length of time necessary for cure, if indeed a cure is possible.

PATIENT: When I come to your office every two or three months, I see you looking at those irregular lines on my chart. You then tell me that my tests are positive, showing that I am fighting the infection and that this, in turn, means that the infection is active so that I am in danger of developing the disease. Could you explain to me how you make that out from those lines? And why more than one test?

DOCTOR: Let me first ask you a question. If you saw or knew that there were armed forces in another country, say in Europe or in Asia, and you further learned that those forces were moving with unusual rapidity, is there anything that you might reasonably anticipate?

PATIENT: I should expect fighting; war would seem likely.

DOCTOR: You are quite right. The world knows that today. Now the allegory is just this: We do two tests of your blood serum monthly

What Readers Say About

"Doctor Pollak's article [August issue] is timely and well worthy of consideration."

"You do well to carry a series on the tuberculosis problem and not alone among employes, professional and otherwise. I can see that you have a problem for extended treatment in The MODERN HOSPITAL."

"There is no doubt in my mind that in states that have an occupational disease act sooner or later hospitals will be confronted with suits under this act on the part of their employes in reference to tuberculosis."

"I heartily agree with the ideas expressed in the article on tuberculosis in the August issue. The first paragraph is a rather unpleasant indictment but one that is only too true. At Trudeau, Raybrook and Mount Morris I repeatedly saw patients who had been treated both by private physicians and hospitals or clinics for considerable periods and who, despite coughing, raising and other signaling symptoms, never had had a sputum examination. Another criticism I would make of the handling of tuberculosis by the average hospital is the reluctance or inability of x-ray men to make a definite diagnosis of tuberculosis. I think they equivocate more than necessary. The clinical people very frequently sit in the same pew."

Dr. William Ogden, F.A.C.P., is director, Chest Clinic, Toronto Western Hospital, and Dr. G. C. Anglin, F.A.C.P., is director, Chest Clinic, Department of Pensions and National Health. A list of references to the literature has been omitted but is available on request.

by Means of Earlier Warning

and G. C. ANGLIN, M.B.

or quarterly; 5 cc. of blood is drawn from a vein in your arm and the laboratory starts the testing on the same day. We are looking for reactions that we have seen take place with the serum of patients actually fighting tuberculous disease. These reactions are evidence of an effort by the defense mechanism of the body to make the patient immune and so are what might be called immunologic, resistant or fighting-back reactions. They are comparable to armed forces.

Those red and black lines on your chart make what we call a graph and they show the degree to which your tests may be positive, whether they are moving or not and, if moving, how rapidly.

You ask why more than one test. Because one test seldom tells the whole story, *e.g.* it cannot tell whether or not they are moving. Both your reactions have been over the positive line—or normal bound-

ary—and both are moving rapidly. A fight is brewing or a fight is on; the warning could not be more plainly written. Too many such warnings unheeded have resulted in the subsequent development of tuberculous disease for us to have any doubt as to their significance. We and our office nurses have seen this happen again and again over a period of years and have seen those with negative tests and straight graphs carry on without trouble.

Because of these years of observing the reactions the nurse is able to sort out the more precarious looking graphs and call these patients in, as you have been called in, to consult with the doctor as to the weekly routine of your work, your rest and your food. This gives us an opportunity to inquire whether you become unduly tired, whether you get the amount of rest required by the average individual and whether you are getting the proper nourishment.

PATIENT: Tell me how many new cases of tuberculosis are found every year in a city of a million?

DOCTOR: About a thousand.

PATIENT: Then in this city of 750,000, there will be 700 new patients with tuberculosis reported this year and another 700 next year and so on?

DOCTOR: Yes.

PATIENT: And do I correctly understand that you are telling me a year or two ahead that my name is likely booked for the 1940 or 1941 list of tuberculosis cases to be reported in this city if I do not slow down and take better care of myself?

DOCTOR: Yes.

PATIENT: It seems to me that is valuable information.

DOCTOR: That's what we think.

THE foregoing type of conversation has taken place (in part or in toto) several hundred times in the last 15 years in the Toronto Western Chest Clinic with 7000 annual attendances or in the private offices of 10 of the clinic physicians. During these years there have been under observation 1300 known intimate contacts to tuberculosis and 400 normals. The latter included medical and university students, nurses in training and patients in general practice. Although 100 per cent assurance in regard to anything may not be claimed for any test, so far not one who took the advice has developed tuberculosis.

Whereas the incidence of tuberculosis among contacts is reckoned in other series as from 20 to 25 per cent, the incidence in our largely controlled series was only 4 per cent and this included many who were not observed regularly. The incidence in our regularly observed normal series was nil.

If so-called contacts give no reaction to the tuberculin skin test, the history given of exposure is not verified, they cannot have been infected, cannot develop tuberculosis (until they are infected) and there

Our Tuberculosis Series

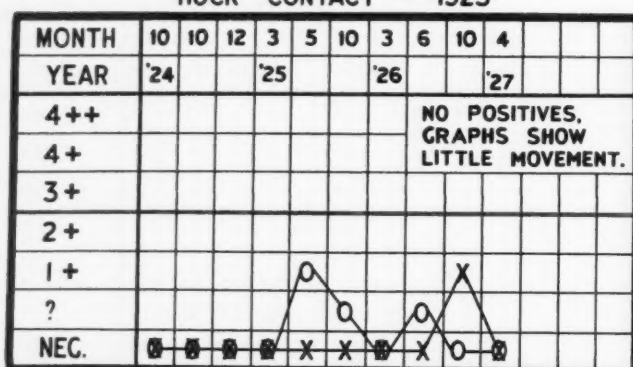
"I am delighted, indeed, to learn that you are making an active fight against tuberculosis on the part of hospitals, as I believe this is one of the best places to strike the disease at this time."

"I feel that hospitals must be classified and each classification considered separately before we can intelligently consider whether or not they are taking proper steps to discover tuberculosis in patients that are admitted for other ailments."

"We have developed a special tuberculosis service housed in the contagious disease building. The percentage of student nurses becoming infected in this service is the lowest of any I have seen reported. I believe that by tightening up the technic in one or two places, we can reduce the infection attack rate to a point only slightly greater than that in the general population."

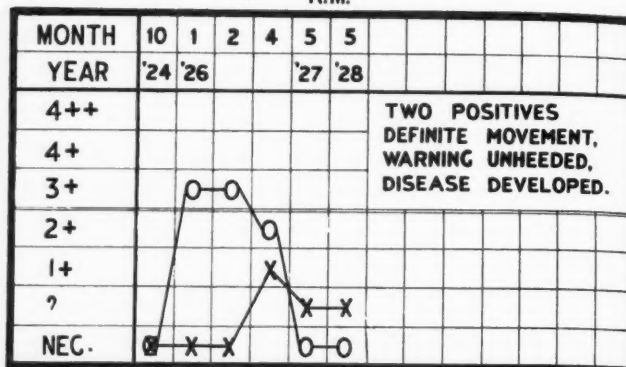
"This is a very serious problem. I doubt, however, whether it is as serious as some of the facts in this [Pollak] article would lead one to believe. Laboratory tests on patients admitted for other than tuberculosis are routine in our hospital. No nurse, intern or employee is engaged without a thorough physical examination including chest x-rays and, on the slightest indication, this is repeated. We have 270 student nurses and since we tightened up in this particular the incidence of tuberculosis has dropped materially."

"HOCK" CONTACT - 1923



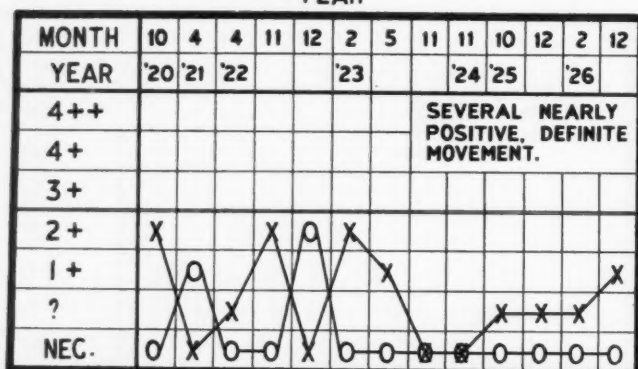
No positive tests, little movement, no warning of approaching disease. Contact still well ten years later.

"R.M."



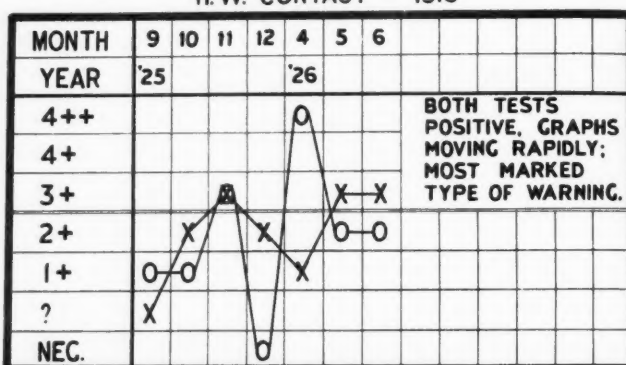
Tests twice positive; no additional care taken. Necropsy three years later demonstrated a tuberculous lesion.

"FLAH"



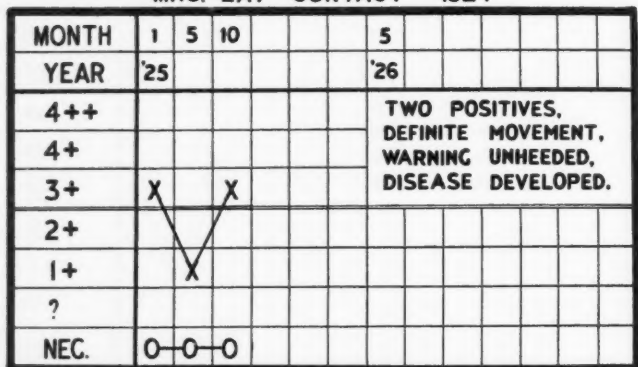
Graph amounts to moderate warning, which patient heeded. The tests then approached the negative line, the graphs straightened out and the patient keeps well.

"H.W." CONTACT - 1919



Warning could not be more plainly written. Patient out of control. Disease demonstrated by x-ray two years later. All findings verified by later films.

"MRS. LAT" CONTACT - 1924



is no object in doing the serum test. Similarly, normals are not serum tested until their semiannual tuberculin test gives a reaction.

Tuberculosis is being kept out of the school for nurses. These tests were first started in the school in 1932 with the approval and cooperation of the principal, Beatrice Ellis. The required extra time off for rest, as designated by the danger-warning graphs of certain pupils, was available in six of the next seven years. In these six years no case of tuberculosis has developed.

The school has 150 pupils. This work was recently described by Grace A. Thomas, staff nurse in charge of the chest clinic. "In this hospital school for nurses we do not wait for an annual x-ray film to demonstrate a lesion in its early stage, when, of course, it is too late for prevention. We are anticipating disease by biological tests and precluding it by extra hygienic care."

The clinical work is based on confidence in the specificity of serial serologic tests for tuberculosis and knowledge of how to interpret them.

In the graphs above horizontal lines have the same terminology as for Wassermann reactions: negative, questionable, 1+ and 2+; positive 3+, 4+ and 4++. Inhibitives are shown thus: o—o; fixations: x—x.

Left: The fixation test was positive twice with definite variation. Warning unheeded. Chest pictures showed clear lung in November; disease developed by next May.

The anticipation or preclinical diagnosis of disease by immunologic reactions is comparatively new in medicine. These tests are Caulfield's inhibitive (discovered by him in 1910) and the tuberculo-complement-fixation, the former revised by Norwich et al. in 1930 and both carried out in Norwich's laboratory at Christie Hospital, Toronto.

If we leave out of consideration for the present the relative amount of infection received (which could be the deciding factor), treatment is based upon our conviction that physical and physiologic fatigue is the largest factor in the development of that infection into disease.

It must be acknowledged that this work could not have been brought to its present state of fruition if it had not had the active interest of the hospital officials through the superintendent, A. J. Swanson.

Administrative Intern

CLAUDE W. MUNGER, M.D.

NO PERSON should be encouraged or even permitted to train for hospital administration unless he or she possesses a solid groundwork of education, a definite interest in the field and, preferably, some sort of preliminary experience or association with hospitals.

Academic preparation for hospital administration is extremely valuable and the ideal combination would comprise (1) an adequate background of general education, (2) a specialized academic course in hospital administration and (3) a period of well-supervised experience in an outstanding hospital. In general, I would want my students to have either an M.D. degree plus a medical internship or a bachelor's degree plus hospital experience or a definite interest in the field.

A nursing course per se is not a sufficient background; any nurse should have a general education equaling or exceeding a baccalaureate degree. Nevertheless, women of proper qualifications have a place in this field and, especially in the smaller hospitals, they find real opportunity. Good nursing is essential to successful hospitalization but other phases of the work are just as important to well rounded success.

Similar criticism may be made of some other specialists who have essayed to administer hospitals. The physician who permits medical practice to dominate and the business efficiency expert who concentrates upon the balance sheet to the neglect of the humane and the professional objectives are examples not infrequently encountered.

The administrative internship cannot work miracles. The extent to which a student can advance will depend upon his groundwork of education, his personality and his administrative ability. Hospitals dif-

In the future, Doctor Munger predicts, fewer administrators will drift or suddenly fall into hospital superintendencies. Formal training will increasingly be recognized as an essential requirement

fer in size, in problems and in aims and there are places in hospital administration for nonmedical persons as well as for doctors. This fact complicates our training programs but should be acknowledged.

In seeking promising candidates for the career of hospital administration, we should not forget hospital departmental workers. Basic educational requirements, however, should seldom be relaxed even for experienced persons.

It must be agreed with the student at the outset that the period of training is to be long enough to give him a complete view of the many phases of a complicated profession. Therefore, it is better not to promise completion of training at any definite date.

In selecting candidates for training, personal characteristics that are likely to promote success must be looked for. Hospitals need administrators who are humanitarians, energetic men and women able to meet people and to assume leadership. Hospital administration holds no place for the educated sophisticate, the petty martinet or, above all, the man who wants an easy job. Quiet persistence, tact, a judicial attitude, good appearance, a sense of humor and the ability to speak and to write about the hospital's work are valuable attributes. Those who have failed in other fields and who seem likely to repeat the process in hospital work must be avoided.

Compensation should not be a primary consideration. The main or only return of the student during his training period should be instruction received and practical experience obtained.

The practical training will have to be varied according to the background of the student. It is preferable that the student live in the institution; only through this intimate association can he understand and appreciate many of the more subtle problems that the administrator faces. In a large hospital it may be worth while for the student to shift his living quarters and dining room seat two or three times during the period of administrative internship in order that he may more thoroughly appreciate the viewpoints and problems of the principal groups or types of employees.

Before actual work assignments are made the student should meet the principal officers of the hospital. It may be well for the administrator to introduce him at the meeting of department heads, explaining the purposes for which he has come to the hospital and soliciting the help, in his training, of all departments. He may be assigned to take the minutes and to do the necessary follow-up work in relation to the meetings of department heads.

The administrative intern's training should be begun by the administrator personally and, as he follows through the various hospital departments and activities, he should be constantly in touch with the executive.

Working assignments for an administrative intern who remains eighteen months in a hospital will be suggested. Under this simple plan, the length of the internship can readily be increased if desired. Persons of unusual preliminary preparation may possibly require less training but, in general, the longer period is desirable. The content of internships probably will not vary widely in different hospitals, even though the order and emphasis in presentation may vary.

Doctor Munger, director of St. Luke's Hospital, New York, originally prepared this report for the American College of Hospital Administrators.

The student should have a desk in the administrator's outer office during the first two months. It is helpful at this period for the student to work closely with the secretary to the administrator, to observe and later to assist her with her work.

At the outset there should be daily sessions with the administrator who will acquaint the student with the organization plan of the hospital and with his own theories and methods in management. Within the first week the student should be assigned a course of collateral reading and should be introduced to the journals dealing with hospital administration. The reading list will naturally reflect the preferences of the administrator and should give consideration to the special requirements of the student.

Collateral Reading Course

Suggested titles include: "Training for the Administrative Career," Davis; "Hospital Organization and Operation," Chapman; "Life of Pasteur," Vallery-Radot; "Hospital Organization and Management," MacEachern; "Legal Aspects of Hospital Practices," Hayt and Hayt; "Hospital Survey for New York," selected reading in all three volumes; "The Care of the Patient," Francis Weld Peabody; historical matter, if available, concerning the particular hospital; "The Great Doctors," Sigerist; regular reading of digests of articles on hospital matters contained in monthly issues of "Hospital Abstract Service"; "Problems and References in Hospital Administration," Hartman; "American Hospital of the Twentieth Century," Stevens, and the professional journals, *Hospitals* and *The Modern Hospital*.

In addition, the student needs practice in the use of the Directory of American and Canadian Hospitals; state medical directory; A.M.A. Medical Directory; A.M.A. lists of Registered Hospitals, Approved Internships and Residencies; American College of Surgeons' List of Approved Hospitals; *The Hospital Yearbook* (check lists, lists of dealers in hospital commodities), and the Directory of American College of Hospital Administrators.

The student should establish a relationship with the hospital librarian who will assist him in obtaining assigned reading material. Ready access to the hospital library will en-

able him to browse among medical as well as administrative material.

A helpful means of giving the intern a grasp of the administrator's work is to assign him to open and read the mail that comes to the administrator's office, both intramural and extramural. He should bring the letters to the administrator at an appointed time, sitting with him while the mail and the problems that it contains are examined. He should be permitted to listen to telephone calls that the administrator answers and to learn how he handles them. He should sit in the office during nonconfidential conferences with department heads or others.

As soon as the student begins to gain some understanding of the work and has become acquainted with the personnel, it is well for him to act as the administrator's messenger to department heads and others in order to obtain departmental information on specific problems. He can transmit special orders to the department heads, explaining them in more detail than is possible in a written order and bringing back the impressions and comments of the department head. Such activities will give the student a general view of the hospital and will begin to give him experience in dealing successfully with varying personalities, a technic that he must master if he is to have a successful future.

Admission of the intern to the administrator's office at the outset of his course conveys the impression to the subordinate staff that the training project is an important matter in the mind of the executive. This reaction will gain the more active help and cooperation of department heads.

From the third to the sixth months of training the student should continue to spend about two hours in the administrator's office each morning to prepare the mail, to be available for conferences and to receive special assignments. The remainder of each day should be spent in some one of the departments where the student should act, insofar as possible, as a working assistant to the department head. It is believed important for him actually to see all aspects of hospital procedures as they are carried out. If the student later becomes a hospital administrator, he will not be able personally to super-

vise all the details of the hospital's work, but he can much more successfully judge performance and deal with problems that come to him from the departments if he has a personal familiarity with the details of their operation.

Nonmedical persons who are being trained for hospital administration should see medical, nursing, and other professional procedures in detail. They should be permitted to follow individual patients through the hospital from the out-patient admitting desk through the clinic to the hospital admitting office, the ward, operating room and on through to discharge.

The student should make and record several case studies of individual patients, with an interpretation of the reasons for the various procedures and with an evaluation of the efficiency with which the various phases of the work for that patient are executed.

Medical Training for Laymen

Lay persons who expect to administer hospitals must be permitted to witness as many surgical operations and like procedures as seem necessary to give them a clear knowledge of these procedures and of the administrator's relation to them. They must learn the details of post-operative care and understand the various nursing and special procedures that are required for the patient.

Naturally, this is the most difficult part of the training of a nonmedical person, but it is the most important part of the work to him because of his lack of such knowledge. If the assistant administrator is a medical person he should supervise the actual case studies that the student makes so that the student may understand clearly what was done and the reasons for the action taken. The administrative intern should be encouraged to fraternize with the medical interns and residents from whom he will absorb much useful information concerning professional work and problems.

After the student has had his introduction to this most important phase of the hospital's work, *i.e.* direct service to patients, he should have working periods in the various departments, such as dietary, house-keeping, physical therapy, social

service, power plant, accounting and laundry. It would be well if he could complete a short term of duty in each department by the end of the sixth month.

From the seventh to the tenth months the student, continuing his two hour morning period in the executive office, may be assigned to work on special problems such as the following: (1) a plan for reducing the consumption of electric current in the hospital; (2) a plan for the conservation of clean linen supplies; (3) a system for key issuance and control; (4) specifications for new equipment that may be needed, following through all the steps of purchase, receipt, approval and installation; (5) devising and putting into operation in a storeroom a system of perpetual inventory; (6) detailed study of the nursing care and nurses' time for several cases; (7) a plan for controlling the use of proprietary and other unnecessarily expensive drugs.

The foregoing special problems are merely suggestive. It is desirable to place emphasis upon the medical phases for the nonmedical intern and upon the business phases for the intern who is a physician or a nurse. The administrative phases will be instructive to both groups.

For the eleventh and twelfth months or elsewhere in the course, if more convenient, the intern should assist with the details of the preparation of an annual budget and an annual report, daily contacts with the administrator being continued.

From the twelfth to the fourteenth months the student may act as a "trouble shooter." He can be assigned to investigate exhaustively complaints from patients, employees and outside persons, formulating a recommended reply, administrative action or other solution of the trouble. He should still continue his daily connection with the administrator's office and should continue any studies still incomplete from the previous period. Throughout the course he should continue to read books and especially current journals relating to hospital work.

The intern should attend medical staff meetings. Here he can make himself welcome by helping the secretary or by operating the stereopticon. He should be unobtrusive but "all ears" at these meetings. He

should be enabled to go to monthly meetings of the local hospital council, if any are available.

Toward the end of his course the administrative intern should be encouraged to attend at least one state or sectional hospital convention. He should by all means have the inspiration provided by attendance at a convention of the American Hospital Association. If the American College of Surgeons meets within a reasonable distance, it would be well for him to attend the excellent hospital conferences that the college sponsors.

The fifteenth (or some other) month should be devoted to vacation and rest, followed in the sixteenth to eighteenth months with a period in which the student will act as executive secretary to the director. During this time he should assist with any or all of the work in the director's office and his work should be watched closely as an aid to his mentor in determining the extent to which he can recommend him for future responsibilities.

Impetigo Combated Successfully

EVERY hospital that has an obstetrical service has encountered from time to time the difficult problem of combating an epidemic of impetigo contagiosum. In spite of the greatest precautions and constant vigilance it will spring up as if from nowhere and spread consternation and anxiety all around.

In February 1938, we had a light epidemic at St. Elizabeth Hospital, Dayton, Ohio. In spite of every precaution taken two or three more cases of impetigo developed. We isolated these infants and assigned special nurses to them. Notwithstanding, two more babies developed the disease. Being unable to trace the source of the infection, we took the following drastic measures:

1. We set up two improvised nurseries, one for new babies and one for the babies that had been exposed. Nurses were assigned to each nursery.

2. The large nursery and all the beds were thoroughly scrubbed and painted. The mattresses were autoclaved and sunned.

Of greatest importance to the student himself is the degree of interest the administrator is willing to take in the very considerable educational job of his training. No administrator should lightly assume this heavy responsibility. It would be very wrong to agree to do the job and then do it poorly. Not only would the student suffer but, if he failed to make good, it would bring embarrassment to his teacher as well.

It goes without saying that the administrator who undertakes to train an apprentice will have to make many sacrifices of his own time and energies. The satisfaction, however, of seeing a protégé learn, develop and mature in hospital administration is considerable.

The long and intimate association necessary between administrator and administrative intern can scarcely succeed except between personalities that can function together. The necessity of selecting the student with great care is, therefore, reemphasized not only for educational background but also for personality.

3. Each new baby brought to the renovated nursery was assigned an individual, sterile pack comprising blanket, pad, diaper, band, shirt, towel and wash cloth and five safety pins rolled up and wrapped in muslin.

4. All diapers and pads were folded four dozen to a package, wrapped in muslin and sterilized.

5. A number of blankets, shirts and bands were wrapped separately, sterilized and kept in readiness for use in changing.

6. All the setups, olive oil, boric solution, applicators, cord dressings and cotton were sterilized every morning.

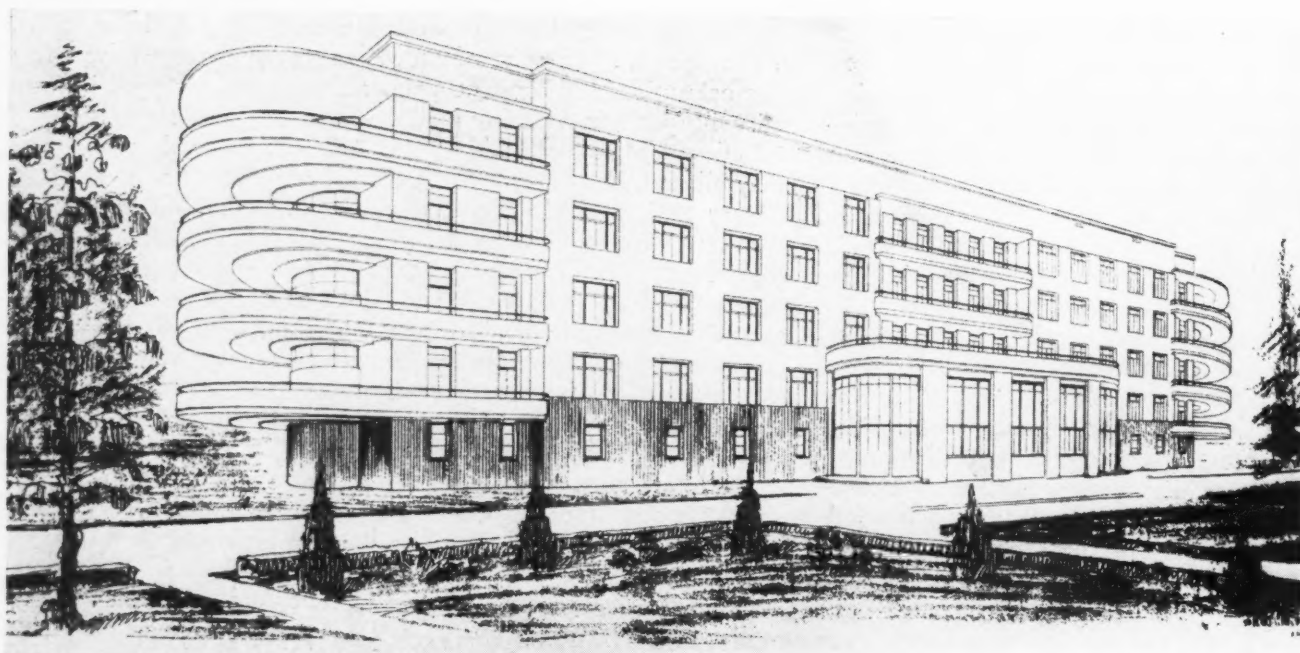
7. Before the baby was passed to the mother for breast feeding, the mother was given an alcohol sponge to cleanse her fingers.

From February 1938 to February 1939 there were 1390 infants delivered, and not another case of impetigo has developed.—SISTER GERARD, R.N., *supervisor of St. Ann's Maternity of St. Elizabeth Hospital, Dayton, Ohio.*



PERU—Maternity Hospital, Lima

Stevens, Curtin and Mason, Architects



POLAND—Sanatorium Near Warsaw

Mieczysław Kozłowski, Architect

A.H.A. Convention Program

Toronto, Sept. 25 to 29

A.H.A. House of Delegates Monday Morning

Social Service Section

Monday, 2:15 p.m.

Chairman: Frank J. Walter, Denver;
secretary: J. Mabel Kniseley, Toronto.

Address: Should the Social Service Department Interview All Hospital Patients? A. K. Haywood, M.D., Vancouver, B. C.

Address: Should the Social Service Department See Only Those Patients Referred to It by the Medical Staff? Harriet Bartlett, Boston.

Discussion: Fletcher McPhedran, M.D., Toronto; Nathaniel W. Faxon, M. D., Boston; Mrs. Aline Paice, Montreal.

Address: The Future of Social Service in the Life of the Hospital, Mrs. Constance Webb, Cleveland Heights.

Discussion: Amy Greene, Baltimore.

Address: The Need of Special Training of the Hospital Social Worker, Agnes Schroeder, Cleveland.

Discussion: Dorothy King, Montreal.

Dietetic Section

Monday, 2:15 p.m.

Chairman: Winifred J. Hoxie; *secretary:* Effie May Winger, Rochester, N. Y.

Address: Nutritive Requirements of the Patient During Disease and Convalescence, F. F. Tisdall, M.D., Toronto.

Address: Problems to Be Faced by the Dietary Department in Meeting These Requirements, Kate Daum, Ph.D., Iowa City, Iowa.

Address: Unification of the Entire Diet Service Administration and Control Under the Dietary Department, Ruth Park, Montreal.

Discussion: Grace Sharpe, Ottawa.

Address: Value of Central Dishwashing, speaker to be announced.

Pharmacy Section

Monday, 2:15 p.m.

Chairman: Worth L. Howard, Akron, Ohio; *secretary:* J. Winfred Tice, M.D., Hamilton, Ont.

Address: Should the Pharmacy Be Responsible for Drugs and Pharmaceuticals Only? C. W. McClintock, Columbus, Ohio.

Address: Pharmacy Intern, H. A. K. Whitney, Ann Arbor, Mich.

Address: Function and Scope of Pharmacy in the Small Hospital, J. G. Barclay, Phar.B., Belleville, Ont.

Address: Manufacturing in the Hospital Pharmacy, (a) Large Hospital, L. N. Hickernell, Cleveland; (b) Small Hospital, speaker to be announced.

Address: The Use and Abuse of the Hospital Pharmacy, E. L. Harmon, M.D., Valhalla, N. Y.

A. H. A. House of Delegates Monday Afternoon

President's Session

Monday, 8:00 p.m.

Concert Hall and Crystal Ballroom,
Royal York Hotel

Invocation and Address of Welcome.

President's Address: G. Harvey Agnew, M.D., Toronto.

Introduction of President-Elect: Fred G. Carter, M.D.

Presentation of Awards.

Reception.

I. H. A. CONVENTION

The meetings of the International Hospital Association in Toronto will begin on Tuesday, September 19. The complete program will be found in the August issue of The Modern Hospital

Tuberculosis Section

Tuesday, 9:15 a.m.

Chairman: Bernard S. Coleman, New York; *secretary:* E. S. Mariette, M.D., Oak Terrace, Minn.

Symposium: Tuberculosis as an Occupational and Compensable Disease, Elizabeth S. Klettsch, Wauwatosa, Wis.; Grant Cunningham, M.B., Toronto, and Lorna Doone Mitchell, West New Brighton, Staten Island, N. Y.

Symposium: Safeguarding Hospital Personnel From Tuberculosis, W. H. Oatway Jr., M.D., Madison, Wis.; Ellen Stahlnecker, Detroit, and H. McLeod Riggins, M.D., New York.

Tuesday, 2:15 p.m.

Symposium: Adequate Institutional Care for the Tuberculous, J. Masur, M.D., New York, and G. C. Brink, M.B., Toronto.

General Discussion.

Address: Medical Records in a Tuberculosis Hospital, Frances C. Nemec, Oak Terrace, Minn.

Small Hospital Section

Tuesday, 9:15 a.m.

Chairman: Jewell W. Thrasher, R.N., Dothan, Ala.; *secretary:* Marjorie Buck, Simcoe, Ont.

Address: Dietary and Housekeeping Management in the Small Hospital, Vera Clark, Guelph, Ont., and Fay Lipsit, Simcoe, Ont.

Address: The Value of the Institutional Personality, O. K. Fike, Richmond, Va.

Address: Modernization of the Small Hospital, A. F. Branton, M.D., Willmar, Minn.

Address: The Importance of a Good Accounting System in a Small Hospital, Gordon A. Friesen, Belleville, Ont.

Round Table on Small Hospital Section

Tuesday, 2:15 p.m.

Leaders: James A. Hamilton, New Haven, Conn., and R. C. Buerki, M.D., Chicago.

Business Management Section

Tuesday, 9:15 a.m.

Chairman: Warren W. Irwin, Rochester, N. Y.; *secretary:* Leonard P. Coudy, Saskatoon, Sask.

Address: The Common Ground, Will Ross, Milwaukee.

Address: Purchasing Procedures, John Hernal, Toronto.

Discussion: O. G. Sawyer, Durham, N. C., and E. E. Thompson, Syracuse, N. Y.

Address: Adaptability of Routine Purchasing Problems to the Smaller Hospital, S. K. Hunt, Morganton, N. C.

Address: Interdepartmental Statistical and Accounting Control, William L. Wilson Jr., Danville, Pa.

Address: Collection Systems and the Problems of Write-Off, George P. Bugbee, Cleveland.

Address: Inclusive Rates, James V. Class, Cleveland, and Ray M. Amberg, Minneapolis.

Administration Section I

Tuesday, 2:15 p.m.

Chairman: Arthur J. Swanson, Toronto; *secretary:* Esther Wolfe, R.N., Minneapolis.

Address: Employee Health Service, Robert E. Neff, Iowa City, Iowa.

1.



1. ENGLAND –

Birmingham Hospital Centre

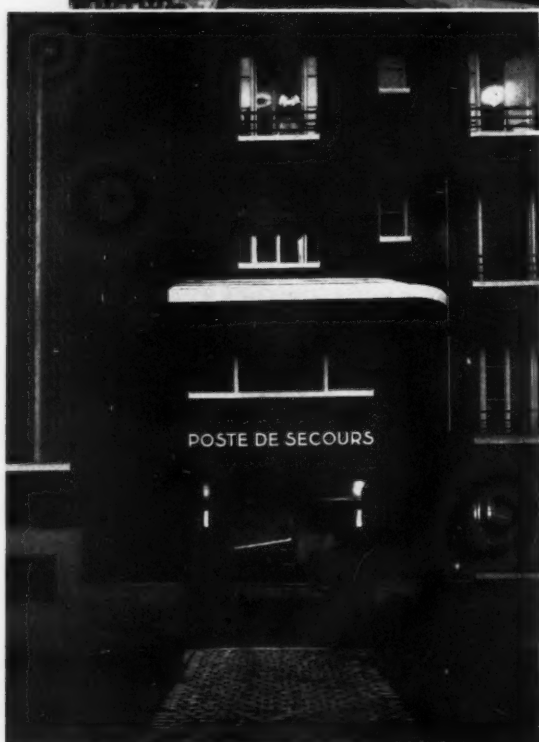
Lanchester and Lodge, Architects

2. FRANCE –

Hôpital Paul Marmottan, Paris

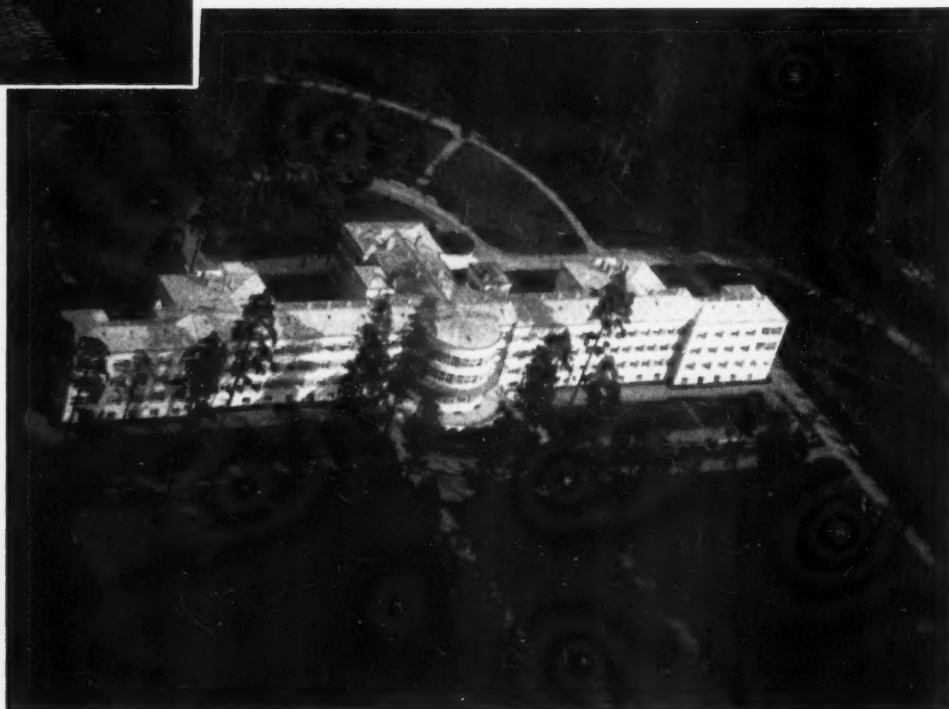
3. LATVIA –

Tuberculosis Sanatorium, Tervete



2.

3.



Address: Training of Hospital Personnel, Edgar C. Hayhow, Paterson, N. J.

Address: Policies of Employment, E. I. Erickson, Chicago.

Address: Methods of Wage Compensation Including Perquisites, John N. Hatfield, Philadelphia.

Address: Labor Turnover, Frank J. Walter, Denver.

Address: Fire Control in Hospitals, John C. Mackenzie, M.D., Montreal.

Trustees' Section

Tuesday, 8 p.m.

Chairman: David B. Skillman, Easton, Pa.; *secretary:* M. J. Norrel, Dallas, Tex.

Address: National Health Program, William F. Montavon, Washington, D. C.

Address: The Selection of Trustees, R. P. Sloan, New York.

Address: The Ideal Hospital Trustee, Curtis R. Burnett, Newark, N. J.

Address: The Contribution That the Hospital May Make to Its Community, Henry J. Cody, D.D., Toronto.

Tax-Supported Hospital Section

Wednesday, 9:15 a.m.

Chairman: James Moss Beeler, M.D., Atlanta, Ga.; *secretary:* P. J. McMillin, Baltimore.

Address: Organization and Financial Policies of City and County Hospitals, Margaret L. Plumley, New York.

Address: Specific Contributions That General Hospitals Can Make to Local Public Health Progress, Joseph W. Mountin, M.D., Washington, D. C.

Discussion: H. L. Rockwood, M.D., Cleveland.

Address: Personnel Problems With Relation to Civil Service and Government Restrictions, George P. Bugbee, Cleveland.

Discussion: George J. Dash, Rochester, N. Y.

Address: The Place of the Government General Hospital in the Hospital Field, the Rev. Alphonse M. Schwitalla, S.J., St. Louis.

Discussion: D. M. Morrill, M.D., Detroit.

Address: The City Hospital as a Teaching Unit of the Medical School, Walter S. Goodale, M.D., Buffalo.

Nursing Section

Wednesday, 9:15 a.m.

Chairman: A. K. Haywood, M.D., Vancouver, B. C.; *secretary:* Lois Blanche Corder, R.N., Iowa City, Iowa.

Address: What Role Does the Student Nurse Play in the Care of the Sick? Marion Lindeburgh, Montreal.

Address: The General Duty Nurse in the Care of the Sick, Sister Patricia, O.S.B., R.N., Duluth, Minn.

Address: The Subsidiary Worker (Attendant) in the Nursing Care of the Sick, Mary Ellen Manley, R.N., New York.

Address: Administrative Problems in the Supervision of the Student Nurse, General Duty Nurse and Attendant, speaker to be announced later.

Address: Prevention of Communicable Diseases Among Nurses in General Hospitals, Joseph R. Morrow, M.D., Ridgewood, N. J.

Discussion: Basil C. MacLean, M.D., Rochester, N. Y.

Hospital Service Plan Section

Wednesday, 10 a.m.

Chairman: Frank Van Dyk, New York.

Addresses: Prospects for Nonprofit Hospital Service Plans, Basil C. MacLean, M.D., Rochester, N. Y.; Channing C. Frothingham, M.D., Boston, and H. B. Folsom, Rochester, N. Y.

Round Table on Hospital Service Plans

Wednesday, 2:30 p.m.

Coordinator: C. Rufus Rorem, C.P.A., Chicago.

A.H.A. House of Delegates Wednesday Afternoon

WEATHER FORECAST

Flannels and fur coats will not be in order during the A.H.A. convention. The average daytime temperature in Toronto the last week in September ranges around 65°F. At night it usually drops to approximately 50°F. Altogether, visitors can be assured of temperate and enjoyable weather all during their stay at the meeting

Construction and Mechanical Section

Wednesday, 2:15 p.m.

Chairman: S. Frank Roach, Jersey City, N. J.; *secretary:* Carl P. Wright Jr., Port Chester, N. Y.

Address: Modern Usage of Ultraviolet Radiation, Elizabeth Chant Robertson, M.D., Toronto.

Discussion: Cornelius J. Kraissl, M.D., New York.

Address: Do We Take Our Power Plant Problems Seriously? Philip W. Swain, M.E., New York.

Discussion: Fraser D. Mooney, M.D., Buffalo, N. Y.

Address: Panel Heating for the Hospital, F. R. Yerbury, A.R.I.B.A., London, England.

Discussion: Charles F. Neergaard, New York.

Address: The Problem Involved to Furnish the Hospital Linen Service, Austin Crowley, New York.

Discussion: Donald C. Smelzer, M.D., Philadelphia.

Women's Hospital Aids' Section

Wednesday, 2:15 p.m.

Chairman: Mrs. Oliver W. Rhynas, Burlington, Ont.; *secretary:* Mrs. Winifred Baldwin, South Orange, N. J.

Address: Can a Hospital Afford to Be Without an Auxiliary? Mrs. Alton Coldbloom, Montreal.

Address: Specific Examples of Services Given to Hospital by Auxiliaries, E. A. Horton, St. Thomas, Ont.

Address: Organizing Volunteers for Effective Service, Mrs. Bud Frankenhof, Los Angeles.

Address: How Best Can Voluntary Service Function in the Hospital? E. Muriel McKee, Brantford, Ont.

Address: A Few of the Many Advantages of a Women's Hospital Auxiliary, E. F. Mason, Peterborough, Ont.

General Session: Governments and Hospitals

Wednesday, 8 p.m.

Chairman: Michael M. Davis, Ph.D., New York.

Address: Public Hospitals in Great Britain and Cooperation With Voluntary Hospitals, George F. McCleary, M.D., London, England.

Address: Hospital Development in France and Belgium, René Sand, M.D., Brussels, Belgium.

Address: Hospital Development in Latin America, Aristedes A. Moll, M.D., Washington, D. C.

Address: Hospitals and Government in the United States, Claude W. Munger, M.D., New York.

Administration Section II

Thursday, 9:15 a.m.

Chairman: Harold T. Prentzel, Philadelphia; *secretary:* Leon S. Lippincott, M.D., Vicksburg, Miss.

Address: Comparison of the Organization and Administration of the English and American Voluntary Hospitals, Capt. J. E. Stone, London, England.

Discussion: Graham L. Davis, Charlotte, N. C.

Address: Diagnostic Clinics—In-Patient and Out-Patient, Frank E. Wing, Boston.

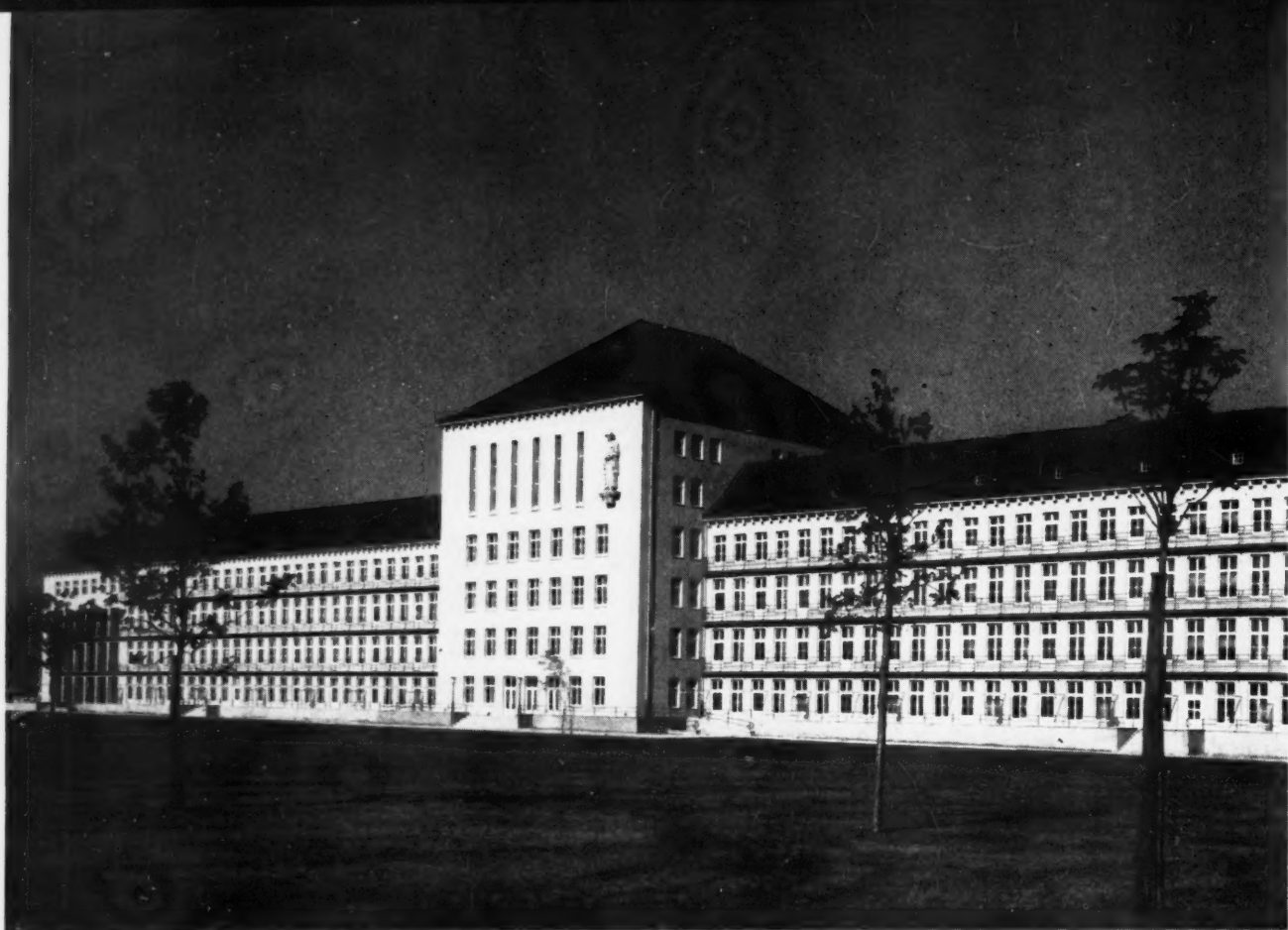
Discussion: Howard E. Bishop, Sayre, Pa.

Address: The Need for Government Assistance to Hospitals and Its Effect Upon the Voluntary Hospital System, William J. Orchard, Orange, N. J.

Discussion: George F. Stephens, M.D., Winnipeg.

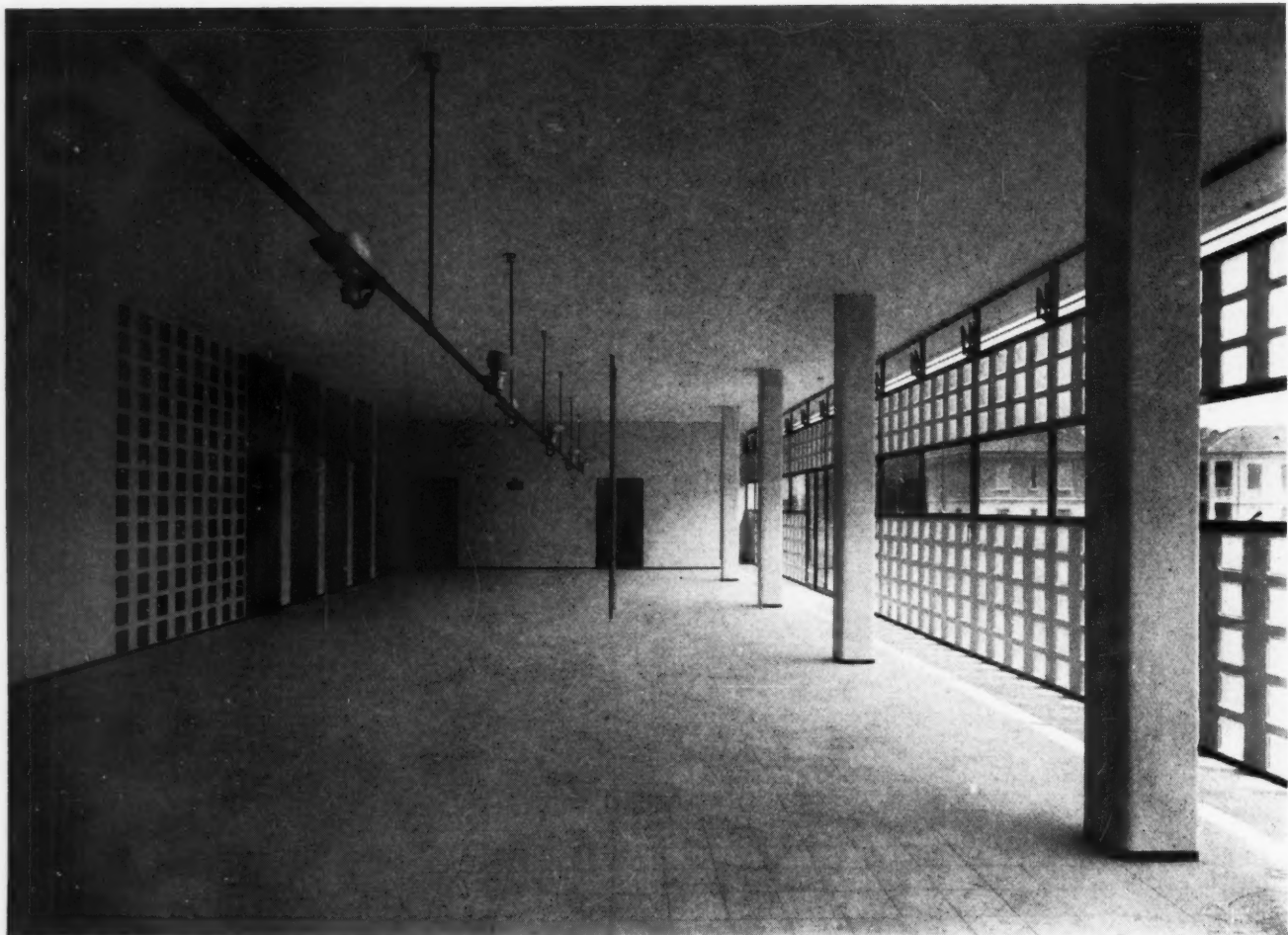
Address: Voluntary Hospitals and the Social Security Act, Basil C. MacLean, M.D., Rochester, N. Y.

Discussion: James A. Hamilton, New Haven, Conn.



GERMANY – Military Hospital, Hamburg

Hermann Distel, Architect



ITALY – Tuberculosis Clinic, Alexandria

I. Gardella and L. Martini, Architects

Out-Patient Section Thursday, 9:15 a.m.

Chairman: Ray Amberg, Minneapolis; *secretary:* B. S. Johnston, M.D., Montreal.

Address: Should All Free Clinics and Dispensaries Be Integral Parts of the Hospital? John C. Mackenzie, M.D., Montreal.

Discussion: George O'Hanlon, M.D., Jersey City, N. J.

Address: Development of the Hospital as a Health Center Through Its Out-Patient Department, George Bugbee, M.D., Cleveland.

Discussion: Nathaniel Smith, M.D., New York.

Address: Trends in Payment for Out-Patient Care in Voluntary Hospitals, Michael M. Davis, Ph.D., New York.

Discussion: Peter Ward, M.D., St. Paul, Minn.

Address: How Should the Expanded Out-Patient Department Be Administered and Financed? A. J. Hockett, M.D., New Orleans.

Discussion: Clyde D. Frost, M.D., Baltimore.

Address: How Does a More Comprehensive Out-Patient Department Fit Into the National Health Program? Donald Morrill, M.D., Detroit.

Discussion: Lewis E. Jarrett, M.D., Richmond, Va.

General Session

Thursday, 9:15 a.m.

Chairman: Rev. Joseph S. O'Connell, vice president, A.H.A.

Address: Dental Clinic and Internships in Hospital, T. L. Marsh, L.D.S., D.D.S.

Address: Administration of Naval Hospitals, Capt. Lucius W. Johnson, Washington, D. C.

Address: The Value of Disease Surveys to the Community, Verna M. Emery, Orange, N. J.

Address: Modern Resuscitation Procedures in Hospital Practice, Gordon Bates, M.D., general director, Health League of Canada.

General Business Session.

Children's Hospital Section

Thursday, 2:15 p.m.

Chairman: Joseph H. W. Bower, Toronto; *secretary:* Margaret E. Orr, Montreal.

Address: They Do Grow Up, William J. Patterson, M.D., Montreal.

Discussion: Marjorie Taylor, Milwaukee.

Address: How the Children's Hospital Can Best Meet Community Needs, Alan Brown, M.D., Toronto.

Discussion: Francis R. Van Buren, Cincinnati.

Address: The Control of Cross In-

fection in Children's Wards, Thelma Kenyon, R.N., Buffalo, N. Y.

Discussion: Jesse V. Buck, San Francisco, and A. J. Hockett, M.D., New Orleans.

Address: Surgical Treatment of Infantile Paralysis, D. E. Robertson, M.D., Toronto.

Discussion: George E. Bennett, M.D., Baltimore.

Round Table on Public Relations

Thursday, 2:15 p.m.

Leader: Arden E. Hardgrove, Louisville, Ky.

Associate Leaders (others to be added): Robin C. Buerki, M.D., Chicago, and Alden B. Mills, Chicago.

General Session: Some Public Problems

Thursday, 2:15 p.m.

Address: Diagnostic Service at Mount Sinai Hospital, New York, George Baehr, M.D., New York.

Address: Helping Hospitals and

Practitioners in Small Communities, Samuel Proger, M.D., Boston.

Address: Voluntary Hospitals and Government, Michael M. Davis, Ph.D., New York.

Banquet and Ball Thursday Evening

Trooping of Colors.

Toasts to King and President.

Address: Sir Gerald Campbell, High Commissioner of the United Kingdom, Ottawa.

Address: F. W. Routley, M.D., National Director, Canadian Red Cross Society.

Induction of President: Fred C. Carter, M.D.

Dancing: Stanley St. John's Orchestra.

Round Table

Friday

Leaders: Robert Jolly, Houston, Tex., and Malcolm T. MacEachern, M.D., Chicago.

A.P.H.A. Convention Program

Sept. 22 to 24

CONVENTION THEME: "The Living God in the Hospitals of the Nations."

Friday Evening, Sept. 22

Joint Meeting With International Hospital Association, Canon H. J. Cody, president, Toronto University, presiding.

Address: Health and Human Progress, René Sand, M.D., Brussels, Belgium.

Address: What Great Britain Is Doing to Improve the Health of the People, W. McAdam Eccles, M.S., F.R.C.S., London, England.

Address: A Health Program for Canada, Frederick W. Routley, M.D., Toronto.

Address: The Rôle of the Hospital in Health Conservation, Hans Frey, M.D., Berne, Switzerland.

Address: Voluntary and State Cooperation in Health Conservation, Rt. Rev. Msgr. Maurice F. Griffin, Cleveland.

Saturday Morning, Sept. 23

Clarence C. Hess, Indianapolis, presiding.

Address: The Past Year and What It Has Meant to Our Protestant Hospitals, Bryce L. Twitty, Dallas, Texas.

Address: Why Are We Here? Rev. Paul R. Zwilling, St. Louis.

Address: Church Hospitals and Legislation, Arthur M. Calvin, St. Paul, Minn.

Address: Church Hospitals and Government Policies; Edgar Blake Jr., Gary, Ind.

Round Table Conference: Spirit of Service to Patients, Robert Jolly, Houston, Tex., and R. E. Heerman, San Francisco.

Saturday Luncheon

Election of Officers and Trustees.

Saturday Afternoon

Guy M. Hanner, Colorado Springs, Colo., presiding.

Address: Development of the Christian Spirit in Our Schools of Nursing, Edna Newman, Cleveland.

Address: Contribution of the Church to the Christian Life of the Hospital, Rev. Harry E. Hess, Omaha.

Address: The Work of a Chaplain in a General Hospital, Rev. Russell L. Dicks, Chicago.

Round Table Conference: Hospital Fund Raising, Alden B. Mills, Chicago, and Arthur M. Calvin, St. Paul.

Saturday Evening

Banquet of Nations: Bryce L. Twitty, president, presiding.

Address: Bishop Francis J. McConnell, New York.

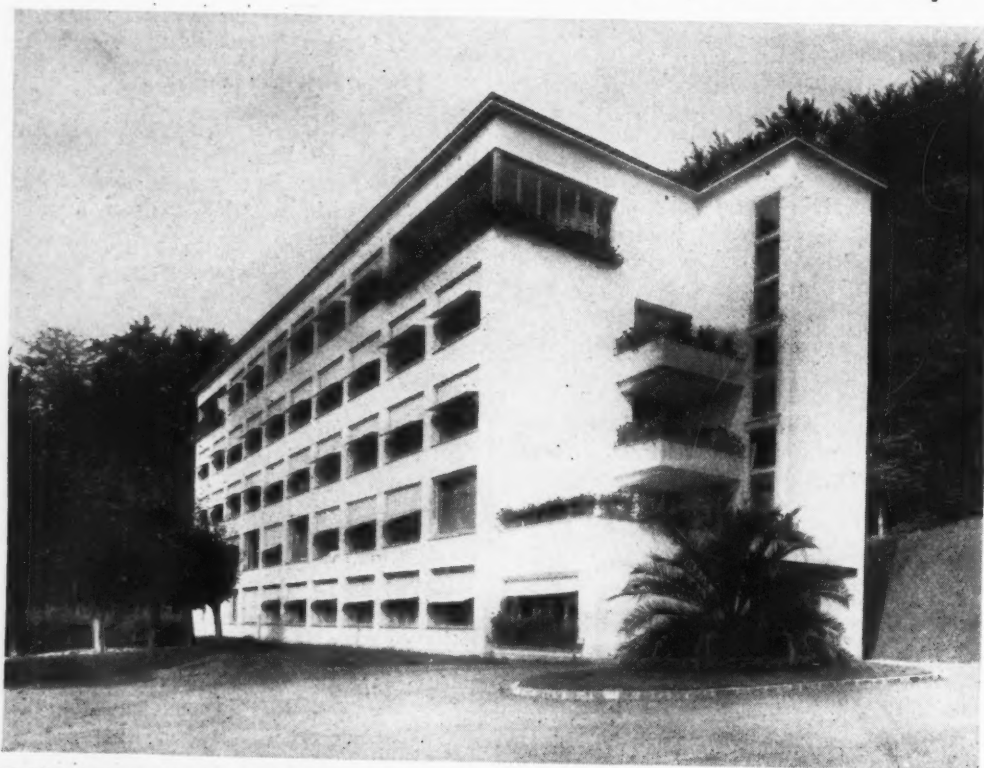
Sunday Morning

John L. Ernst, Ph.D., Detroit, presiding.

Address: Rev. Herman L. Fritschel, Milwaukee.



SWEDEN—County Sanatorium, Upsala County Gustaf Birch-Lindgren, Architect



SWITZERLAND—Cantonal Hospital, Lucerne

A. C. H. A. Names Members and Fellows

New members of the American College of Hospital Administrators, as well as new fellows and those who have been advanced from membership to fellowship in the college have been announced. Memberships and fellowships will be conferred at a special convocation to be held on Sunday, September 24, at 3 p.m. during the annual meeting of the college in Toronto, September 22 to 25.

Advanced to Fellowship

Alberta, Sister, St. Mary's Hospital, Milwaukee.
Barron, William E., Washington Hospital, Washington, Pa.
Bernard, Sister Marie (Masterson), St. Joseph Mercy Hospital, Pontiac, Mich.
Bradley, F. R., Barnes Hospital, St. Louis.
Brandt, Henry T., Deaconess Hospital, Buffalo, N. Y.
Burt, George R., Piedmont Hospital, Atlanta, Ga.
Claiborne, Estelle D., St. Louis Children's Hospital, St. Louis.
Dent, A. W., Flint-Goodrich Hospital, New Orleans.
Dunstan, Dr. E. M., Dallas County Hospital System, Dallas, Tex.
Folendorf, Gertrude, Mrs., Shriners' Hospital, San Francisco.
Hummel, Stuart K., Silver Cross Hospital, Joliet, Ill.
Johnston, Margaret W., Beloit Municipal Hospital, Beloit, Wis.
Lanpher, Lee S., Lutheran Hospital, Cleveland.
Lindquist, Charles A., Sherman Hospital, Elgin, Ill.
McIntyre, M. Ellen, Meriden Hospital, Meriden, Conn.
Pratt, Oliver G., Salem Hospital, Salem, Mass.
Reginald, Sister Mary (Dexter), De Sales College, Toledo, Ohio.
Riese, Mildred, Orthopaedic Hospital, Los Angeles.
Skeoch, Mary E., St. Luke's Hospital, Marquette, Mich.
Smith, Mary A., North Hudson Hospital, Weehawken, N. J.
Veronica, Sister Mary (Ryan), John B. Murphy Hospital, Chicago.

Advanced to Membership

Clay, Dr. Clement C., St. Barnabas Hospital, St. Paul.
Clark, James R., Southside Hospital, Bay Shore, N. Y.
Hargreaves, W. K., Pontiac General Hospital, Pontiac, Mich.
Lydia, Sister, St. Vincent's Hospital, Birmingham, Ala.
Rourke, A. J. J., University of Michigan Hospital, Ann Arbor, Mich.
Smith, Ann Brown, McKinney City Hospital, McKinney, Tex.

Elected to Fellowship

Allen, Dr. Wilmar M., Hartford Hospital, Hartford, Conn.
Armstrong, R. Fraser, Kingston General Hospital, Kingston, Ont.
Avellino, Sister Mary, Mercy Hospital, Wilkes-Barre, Pa.
Chenoweth, W. R., Royal Victoria Hospital, Montreal, Que.

Copeland, Margaret, Free Hospital for Women, Brookline, Mass.
Damian, Sister Mary, Sisters of Charity, Villa de Matel, Houston, Tex.
Engelbach, Dr. Albert G., Cambridge Hospital, Cambridge, Mass.
Freeman, Dr. George H., St. Peter State Hospital, St. Peter, Minn.
Fulgencia, Sister Mary (Frisch), Creighton Memorial, St. Joseph's Hospital, Omaha, Neb.
Howe, F. Stanley, Orange Memorial Hospital, Orange, N. J.
Kerlikowske, Dr. Albert C., University of Michigan Hospital, Ann Arbor, Mich.
Key, Sara L., St. Luke's Hospital, New Bedford, Mass.
Lilley, Dr. Alan B., Royal Prince Alfred Hospital, Sydney, Australia.
Pollak, Dr. Maxim, Peoria Municipal Tuberculosis Sanitarium, Peoria, Ill.
Roy, Joseph, St. Luke's Hospital, Montreal, Que.
Salsbury, Dr. Clarence G., Sage Memorial Hospital, Ganado, Ariz.
Shaw, Elizabeth, St. Margaret Memorial Hospital, Pittsburgh.
Snively, Dr. E. H., Newark City Hospital, Newark, N. J.
Stewart, Alice, Tuberculosis League Hospital, Pittsburgh.

Elected to Membership

Aarsrud, Gena K., Lutheran Hospital, Bemidji, Minn.
Ackerman, Dr. Stephen H., Fordham Hospital, New York.
Adelaide, Sister M. (Bierwiler), St. Joseph's Hospital, Parkersburg, W. Va.
Agathina, Sister Mary, St. Elizabeth Hospital, Lincoln, Neb.
Aita, A. A., San Antonio Community Hospital, Upland, Calif.
Angela, Sister (Hofstetter), St. Vincent's Hospital, Jacksonville, Fla.

Austin, Casper M., Sioux Valley Hospital, Sioux Falls, S. D.
Bateman, Edith F., Shriners' Hospital, St. Louis.
Beddoe, Dr. Robert E., Stout Memorial Hospital, Wuchow, South China.
Boyd, Robert, Presbyterian Hospital, San Juan, P. R.
Brandner, Ann, St. Louis Children's Hospital, St. Louis.
Canuta, Sister M. (Drobish), St. Edward Hospital, New Albany, Ind.
Carder, O. J., Missouri Methodist Hospital, St. Joseph, Mo.
Carmel, Sister Marie (MacKinnon), St. Rita Hospital, Sydney, N. S.
Clementine, Sister (Nee), St. Thomas Hospital, Nashville, Tenn.
Cohen, Samuel S., Jewish General Hospital, Montreal, Que.
Corbitt, Alma C., Charleston General Hospital, Charleston, W. Va.
Crescentia, Sister M. (Wickenhauser), St. Francis Hospital, Evanston, Ill.
Dickson, Emma B., Chippewa County War Memorial Hospital, Sault Ste. Marie, Mich.
DeBusk, Dr. Roger W., St. Luke's Hospital, New York.
DeYounge, Myrtle, John T. Mather Memorial Hospital, Port Jefferson, N. Y.
Dougher, Julia L., Hudson City Hospital, Hudson, N. Y.
Dow, Miriam L., Franklin County Memorial Hospital, Farmington, Me.
Dutton, Edgar E., Galt Hospital, Lethbridge, Alta.
Elliott, Paul C., Presbyterian Hospital, Los Angeles.
Entley, William D., Arnot-Ogden Memorial Hospital, Elmira, N. Y.
Ferraro, Palma M., Leonard Hospital, Troy, N. Y.
Flath, Carl I., Wellesley Hospital, Toronto, Ont.
Forbus, Sample B., Watts Hospital, Durham, N. C.
Frank, Dr. William W., Hinsdale Sanitarium and Hospital, Hinsdale, Ill.
Gertrude, Sister (Kelly), St. Mary's Hospital, Saginaw, Mich.

(Continued on page 138)

A.C.H.A. Convention Program Toronto, Sept. 22 to 25

International Luncheon Conference

Friday, 12:30 p.m.

Chairman: Robin C. Buerki, M.D., Chicago.

Address: The Need for Training in Hospital Administration, G. Harvey Agnew, M.D., Toronto.

Address: England's Experience in Hospital Administration Training, Joseph E. Stone, Birmingham, England.

Address: Training in Hospital Administration at the University of Chicago, Arthur C. Bachmeyer, M.D., Chicago.

Address: The Administrative Internship, Ada Belle McCleery, Evanston, Ill.

Address: Institutes in Hospital Administration, Malcolm T. MacEachern, M.D., Chicago.

Saturday, 3 p.m.

Election of Regents.

Sunday, 10 a.m.

General Business Session.

Sunday, 3 p.m.

Convocation.

Sunday, 7 p.m.

Banquet.

Sunday, 9 p.m.

President's Reception.

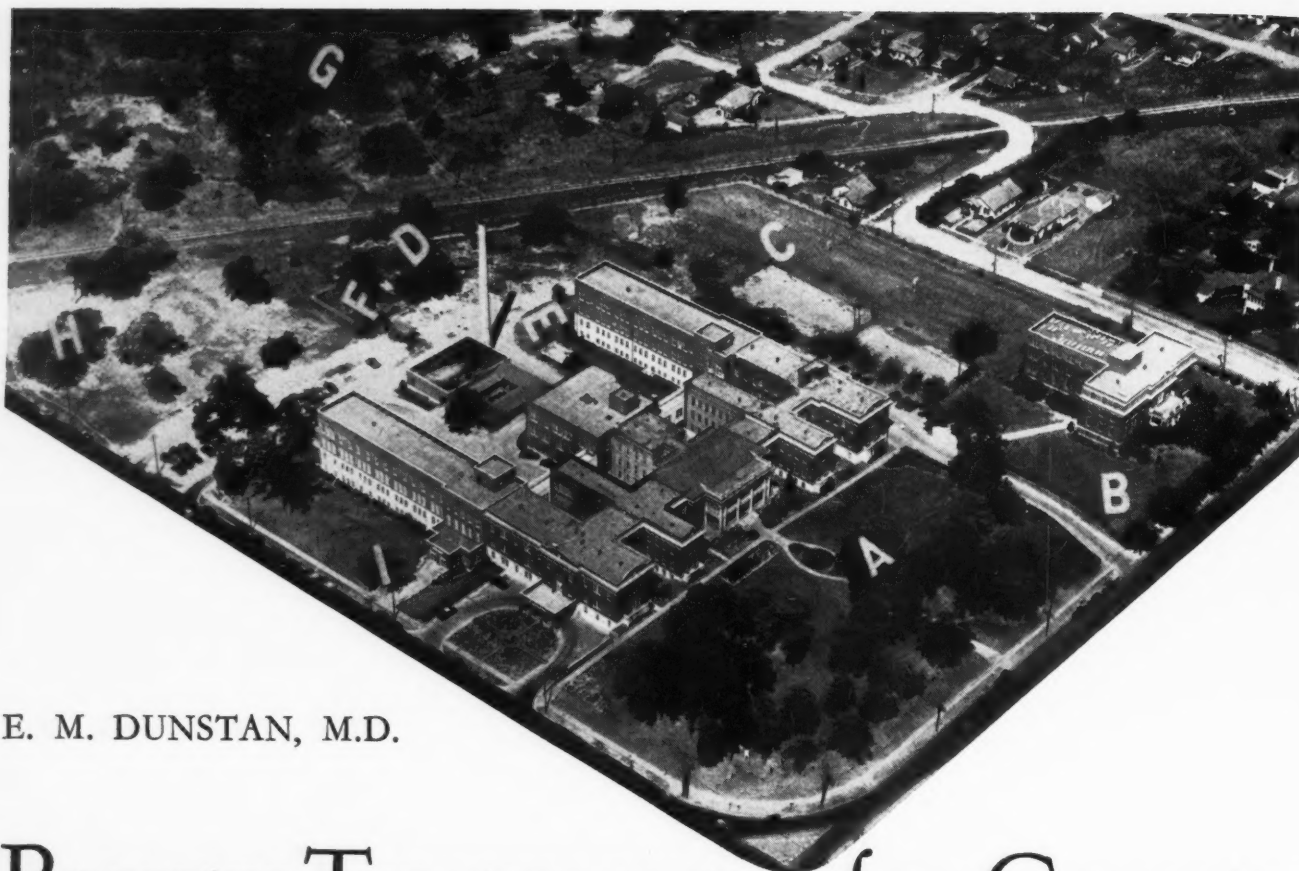
Educational Session

Monday, 10 a.m.

Address: Code of Ethics, G. Harvey Agnew, M.D., Toronto.

Address: Trustees' Conference, Arthur C. Bachmeyer, M.D., Chicago.

Symposium on Institutes: Ray Amberg; B. W. Black, M.D.; Graham L. Davis; Malcolm T. MacEachern, M.D., and Claude W. Munger, M.D.



E. M. DUNSTAN, M.D.

Beauty Treatment for County



Above: The lawn in front of the clinic and emergency entrance. Left: Playground for nurses and the intern staff.

CULTIVATION of the exterior of a city or county hospital is always a difficult problem and one that is often neglected for obvious reasons. Relatively few charity institutions have an adequate budget. At Parkland Hospital, the general unit of the city-county hospital system of Dallas, Tex., civic support was enlisted to beautify the hospital property at practically no expense to the institution itself. An account of this undertaking, simple in its conception and execution but tremendous in the actual labor involved, will be given with the thought that it may be of practical aid to other hospitals faced with the same problem. In Dallas, the improvement program became a cooperative enterprise between the two garden clubs of the Dallas Woman's Club, the National Youth Administration and the county commissioners who, with the city government, finance the operation of the hospital.

The improvement program had its inception about a year ago. A benefit entertainment, in the nature of a pil-

Doctor Dunstan is superintendent of the Dallas City-County Hospital System, Dallas, Tex.

grimage to inspect distinguished Dallas homes and estates, was conducted in April 1938, from which the garden clubs realized \$2000 to finance their part of the undertaking.

The women's voluntary offer came at an auspicious time, since Parkland had been engaged in an expansion program during the preceding year. New wings had been built, equipment added and other improvements made through a \$550,000 P.W.A. building project. With the federal government already assisting the institution, it was a simple matter to enlist continued aid from this source for further improvement. The N.Y.A. adopted the beautification plan as one of its work projects at the hospital. Thus the gardening and landscaping labor was provided. More than 250 boys, working in rotation, have engaged in this activity, many gaining sufficient training in the nursery trade to equip themselves

of care. When the present building was erected in 1913, the women's clubs had donated a large amount of shrubbery which, while still attractive and useful, was in bad condition and had grown out of proportion. The dumping grounds in the rear of the institution had stifled much natural growth and the improvement of this section was one of the most difficult tasks.

A serious obstacle was the lack of a water supply to maintain the grounds after improvements were made. In all the large acreage, there were only two small water connections. Adequate irrigation was essential.

From the garden clubs' funds, a sum was budgeted for the installation of a simple but efficient watering system. A 2 inch main was extended over the property from the street in three sections. With an outlet at ground level every 100 feet, the lawns

than 100 years old, offered the chief natural asset but, owing to the distribution of soil from old excavations, they had become deeply embedded and were slowly dying. This condition was found to be general throughout the wooded areas and the same corrective means, *i.e.* a process of aerating the roots, was employed throughout.

This meant digging ditches, 2 feet wide and 4 feet deep, around each tree or group of trees in a wide radius beneath the full drip of the branches to allow the free circulation of air to the roots. In these ditches, a layer of rocks was laid first with hollow drainage tiles, set in at intervals of 10 feet, rising to the surface to allow the roots to "breathe" fresh air and to receive periodic fertilization. The ditches were then filled with straw, fertilizer and rich black dirt.

With this accomplished, thought was turned to the grassy lawn and flower beds. More than 500 square yards of black soil, donated by the county commissioners, was distributed; the lawn was weeded and sodded with Bermuda grass to cover the bare patches. Rose beds, which broke the symmetry of the lawn, were removed in order to provide a solid grassy plot.

The old shrubbery along the building was healthy but had grown too large for the best effect. This was transplanted to other areas and the beds were fertilized and replanted with a variety of new evergreens and flowering shrubs of uniform size. By thoughtful planning, a continuous rotation of varicolored foliage is seen through the changing seasons as the various shrubs and plants bloom. Beds across the 415 foot frontage of the building include Baker arbor vitae hedge, abelia, wax leaf ligustrum, nandina, mountain laurel, yellow jasmine, King Alfred narcissus, nasturtiums and two large Pfitzer junipers, which were placed on each side of the entrance steps. The walk approaching this entrance divides and rejoins to form a large flower bed. Here abelia and japonica shrubs have been planted in a star design to form the emblem of the nursing school.

The nurses' home is located 50 yards or so from the hospital building and this lawn, marked "B," was given much the same treatment. The old overgrown shrubbery was re-

Hospital Grounds

for future private employment in some branch of horticulture.

The county commissioners joined enthusiastically in the undertaking and gave invaluable cooperation and assistance. They provided machinery and materials for grading the property and building an internal road system.

Then, with the materials and labor at hand, the plan was outlined in detail. A local landscape architect volunteered to draft blueprints and to serve in an advisory capacity. The hospital employed a qualified and competent gardener to direct the work, and his salary has been practically the only expense to the institution.

The first step was to survey the property and to determine its assets and liabilities. It is significant that all the former vegetation was conserved and utilized, with nothing discarded.

The natural wooded land, with native hackberry, elm and oak groves, gave a splendid background, as did the spacious open lawn across the front entrance, although both had been allowed to deteriorate from lack

could be irrigated with the use of standard, single 50 foot hose lengths, each one reaching half the distance between hydrants.

With these essentials provided, a general program was outlined by the cooperating groups; this included the cultivation and conservation of the trees, lawn and shrubs; removal of rubbish heaps; leveling and terracing the grounds; asphaltting and graveling walks and driveways; provision of adequate parking space for staff and public; building a garage for the use of house doctors, and building a greenhouse to serve as a center for the landscaping program and as a constant feeder for further planting and upkeep.

The property was then divided into areas, as shown in the aerial photograph, which was taken three months after the project started for the purpose of studying the requirements and improvements needed.

The spacious, shady front lawn of 3 acres, designated as "A," was one of the few sections still under cultivation; even this needed drastic measures for protection and conservation. The many trees, some of them more



The greenhouse is the center of activity in the landscaping program.

moved to the rear and new shrubs were planted. With sodding and treatment of trees, this front lawn forms a continuation of the broad hospital lawn. The brick walk from the nurses' home to the hospital was widened and bordered with flower beds.

Two special interests of the garden clubs are the cultivation of redbud trees and fine varieties of irises. These have been widely used in the new planting. The beds along the nurses' walk are planted with 25 varieties of irises, donated from the gardens of club members.

One large bed in this section was designated for a rose garden and to this was transplanted the old rose bushes from area "A." To these were added a fine variety of Cherokee climbers, which bloom in profusion from early summer to late fall.

The side area, "C," was made into a sunny playground for nurses, the house staff and other personnel. Here were placed two excellent tennis courts, one illuminated for night playing, volley ball, basketball, archery and badminton courts, and swings. This unit is enclosed on three sides with a beautiful 6 foot aluminum bronze fence, 700 feet long, banked with shrubbery and a row of 50 cedars. This fencing was donated by the park board from the Texas Centennial grounds after the close of the exposition. Cydonia, spirea, crêpe myrtle, redbud and forsythia shrubs, planted along the fence in a wide bed, give the same rotation of bloom and greenery as in the front beds.

"D" is a continuation of the staff's playground. Formerly a creek bed,

this plot had washed to a depth of 15 feet and was filled with rubbish. The ravine was cleaned out, filled and leveled in the grading process, sodded and surrounded with 75 native Texas red cedars. The old shrubbery transplanted from the front beds proved to be a desirable height for enclosing this private park. Here are combined forsythia, japonica, crêpe myrtle and bridal wreath. A storm sewer was put in to drain off excess rain water. Picnic tables and benches and a large barbecue pit were placed under the rejuvenated trees.

The greenhouse measures 16 by 30 feet and is protected against hail storms. It is located between the two new wings and is designated in the photograph as "E." Steam coils from the boiler room supply heat for the propagating beds and even the most delicate plants can be cultivated in its constant temperature.

In addition to their \$2000 cash gift

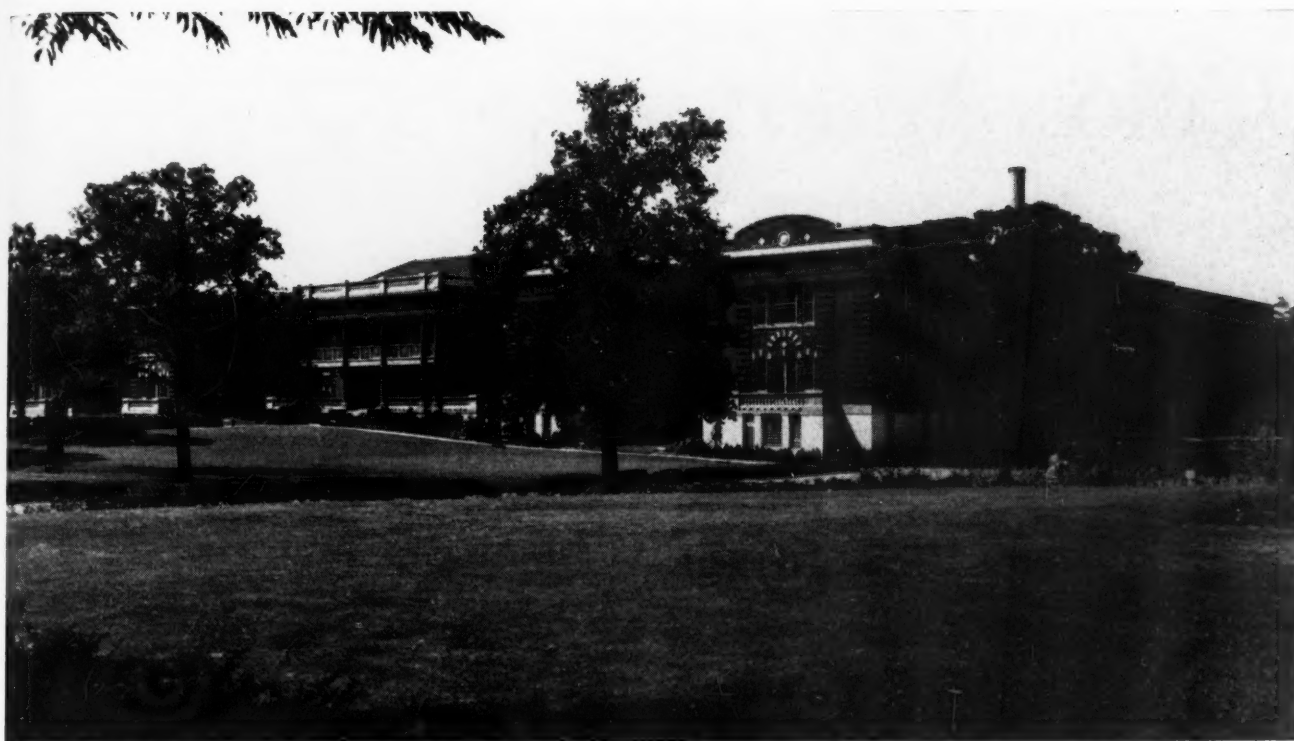
for the purchase of special shrubbery, tools and the watering system, the garden club members have supplied from their own gardens abundant cuttings and seeds from which to propagate for additional planting. Inexpensive cold frames and hot beds have been built just outside the greenhouse, in a fenced-off protected area, for transplanting in the various stages of cultivation; mint and parsley beds were planted for the hospital kitchen. Complete vegetable gardens and orchards were planted at the other units of the system.

Under the direction of the gardener, the greenhouse became the center of activity in the landscaping program. More than 100 varieties of flowers and plants have been cultivated there since last September.

Products from the greenhouse brighten the hospital interior as well as the outdoor scene. Boxes of greenery and potted plants are distributed among the wards and divisions of all units of the system, including the tuberculosis and the convalescent hospitals. Since 97 per cent of Parkland patients are charity cases and the other 3 per cent come from families with low incomes able to pay only minimum rates, floral gifts brought to patients by their visitors are exceedingly rare. Colorful blooms, however, have a definite psychologic effect on the sick and these are now provided from the greenhouse. Also, every nurse who desires one is given a flower box for her room. In six months, more than 400 of these boxes, with from four to six plants each, have been distributed throughout the hospital.



This attractive picnic ground for visitors was once a squatters' camp.



Areas "A" and "B" of the landscaping project are the shady front lawns of the hospital and the nurses' home.

Necessary to the operation of a hospital but usually most unsightly are the waste disposal equipment and the animal pens. These, with other new practical additions, form one unit, "F," which has been made actually attractive despite its purely utilitarian purpose. Here are a concrete garbage house for storing wet refuse; an incinerator; guinea pig and rabbit pens for laboratory use; the gardener's tool and storage house, and a new 23 car garage with graveled driveway for ambulances and staff cars. Ample storage space has been provided for the usual junk that accumulates around a hospital. Around this unit is additional fencing, such as that around the nurses' playground. It is banked with tall shrubs and hedges from the front lawn, thus excluding from view bare and unattractive quarters.

Across the rear and north side of the hospital and between the projecting wings, wide graveled and asphalted roads and concrete sidewalks have been laid. In the spacious parking areas private zones are provided for staff doctors' cars and public zones, for clinic patients' and hospital visitors' cars. This internal road system was built with N.Y.A. labor, with materials and machinery provided by the county commissioner of the district in which the hospital is located.

One large part of the Parkland property in the far rear, separated from the nearer hospital grounds by a railroad track, had been disregarded for many years. This wooded region of native oak, hackberry and elm trees, with two bubbling springs, had been used as a garbage dumping ground; eventually it was appropriated as a squatters' camp by 18 destitute families who had erected unsightly tents and shacks for shelter.

The scenic possibilities of this plot for use as a public park were recognized by the landscape architect who advised with the planning committee. First, the families were removed elsewhere and assisted in building more habitable dwellings. The underbrush was cut away, rubbish was removed, holes were filled in and the ground was graded and the trees were trimmed and aerated. Now, with picnic tables set about, this is a delightful shady park where early hospital visitors may await visiting hours or may retire at mealtime to eat box lunches brought from home when spending the day with patients. This area is indicated on the photograph as "G."

More dumping ground was reclaimed in area "H," when about 4000 square yards of dirt, deposited from the new wing excavations, was moved to low places over the grounds and the area leveled, terraced and re-

sodded. A border of more of the old, tall shrubbery, including red-bud, vitex, tamarix and Baker arbor vitae hedge, obscures the view of the railroad tracks and has made a beautiful corner. A soft ball court was laid out for the hospital personnel, and additional picnic units were set up for visitors.

The last area to be given attention was the side lawn, "I," which had been partially cultivated and was not unattractive in its previous state. The absence of shade trees to obscure the sunshine made this ideal for growing the more delicate and decorative flowering plants, and redesigning was postponed until the spring planting season.

The old shrubbery, grown tall and out of proportion, was transplanted to the rear areas where height was desirable. Stone benches for the use of waiting clinic patients were placed along the walks. The flower beds are to be landscaped with trim new abelias, flowering pomegranate, pyracantha and other shrubs. In front of these perennials will be planted Shasta daisies, May daisies, chrysanthemums and nasturtiums, to give a profusion of blooming color as the season progresses.

After a year of effort, the improvement program is still not entirely finished but every day's work shows that rapid strides are being made.

"Color Added"

RALPH P. CREER

MEDICAL subjects lend themselves particularly well to color photography, especially for teaching purposes in medical schools and hospitals. For the doctor and medical student, color photographs illustrate the subject more clearly. Reproductions of dermatologic lesions are much more impressive and significant when they are shown in natural color. To name only a few, there are tumor lesions and reactions to radiation therapy, burns, arsenical keratosis, lichen planus, eczema, hemangioma, psoriasis, measles and pigment changes in the skin.

Minute color contrasts are equally well demonstrated on pathologic specimens removed at operations or necropsies. Often lack of space makes it impossible for the pathologist to keep the specimens for a museum exhibit and in many instances he cannot retain the original color of the specimens. However, an exhibit of color pictures made from selected fresh specimens will occupy far less space and the slides or color transparencies may be used at staff meetings of the pathologists and to illustrate lectures at medical conventions.

Clarifies Clinical Subjects

It is difficult to demonstrate histology to large groups. Here again color photomicrographs of chosen areas of stained tissue, as well as blood changes, such as anemia, leukemia, polycythemia and many more, can be shown with greater clarity when the color pictures are projected on the screen. A greater number can witness the demonstration and take part in the discussion.

There are a great number of color photographic processes on the market. Regardless of the technic employed, the immediate result is a transparent film or plate that must be viewed by transmitted light or

Mr. Creer is chief clinical photographer at the Veterans Administration Facility, Hines, Ill., and a fellow of the Royal Photographic Society of Great Britain.

Color photography, which is becoming so important in medicine and surgery, is not a new art. It became practicable nearly half a century ago, but it is only recently that it has received recognition

projected on to a screen much the same as a regular lantern slide. Color prints can be made from these transparencies but the intricate formulas and procedures are still somewhat complicated for the amateur technician. Several commercial photo-finishing companies specialize in this type of work and will make an 8 by 10 inch enlargement for about \$10 for the first print and \$4 for the second.

Color Filter May Be Needed

When photographing medical subjects in color, one must keep in mind several factors that are relatively unimportant in the usual black and white process. The source of light must be properly balanced with the type of film or plate used; otherwise the finished picture will show an unnatural color. For example, if the source of light is too yellow, the final result will take on a reddish cast, and if there is too much blue in the lighting, the entire picture will appear to have a bluish tinge. In cases in which the source of light cannot be controlled, a compensating color filter is essential. Specific instructions as to the type of light source or filters to be employed are published by the manufacturers of color sensitive materials and these instructions should be followed implicitly.

In black and white photography the tone contrast is in a measure determined by highlights and shadows, whereas in color work the normal color contrast in the subject itself is

Teaching Is Aided by the Use of Color Photography

usually enough to give the finished picture a brilliant tone quality. Therefore, a flat front lighting without strong shadows will produce better results. If the subject has little color contrast to begin with, a moderate cross lighting may be necessary.

In color films there is less latitude. For this reason correct exposure is essential. Underexposure or overexposure will result in an unnatural color picture; a reliable exposure meter, if used properly, will prove invaluable.

The selection of a background in color photography is highly important. A brilliantly colored background must not be used; otherwise the observer will have a tendency to look at the background before he views the subject. In order to keep the color contrast at a minimum, a black, white or neutral gray background should be used when photographing medical subjects.

Correct Illumination

Care must be taken to avoid a mixture of various kinds of illumination. For instance, if the type of color film is color balanced with photo-flood bulbs only, no stray light from an electric light bulb of lower light value and certainly no daylight should be permitted to fall upon the subject. A gray, black or dull white drape will prove satisfactory in making most surgical pictures in color.

Although color photography is now reasonably simplified and within the financial means of every advanced amateur, few color illustrations are published in scientific journals and textbooks. This scarcity is not due to a lack of progress on the part of the photographer but to the high cost of reproduction.

Because of the ever increasing demand for true color reproduction, the now almost prohibitive cost of registering color may gradually be brought down to a more popular price level, with the result that more color illustrations will find their way into many of the scientific publications.

The Question of Insurance

IVAN R. LASHINS

TODAY the types of insurance required by and available to hospitals are numerous. For example, institutions should carry:

1. Compensation insurance, which is an insurance requirement imposed by law upon employers whose employees may sustain injuries during the course and scope of employment.

2. General public liability, which indemnifies for loss against claims resulting from accidents on hospital premises, sidewalks or adjacent ways.

3. Employees' fidelity, a form of blanket bond covering in one sum all employees embraced therein and protecting the insured against loss of money caused by larceny, theft or forgery.

4. The four types of ambulance insurance, *i.e.* collision, public liability, property damage and fire and theft.

In addition, various other kinds of insurance are in some cases as much needed as those mentioned. The coverage depends upon the particular needs of the institution and the policies of its governing board. These include malpractice, elevator, radium, plate glass and the loss of patients' property.

Deductible Clause Lowers Cost

Policies, such as ambulance collision and boiler insurance, can be obtained with deductible clauses. Under the deductible clause the amount specified, for example, \$50, is first deducted from any loss and the excess is the claim payable by the insurance company. The advantage of the deductible coverage policy is that it carries a much lower premium than a full coverage policy and yet affords protection in case of serious damage.

I have mentioned public liability insurance among the different types of insurance required by institutions. A questionnaire by the United Hospital Fund in 1932 revealed that only

about half of the hospitals so queried carried this type of insurance. It may be that the institutions not so insured have relied on the common law doctrine of total immunity, *i.e.* that the funds used to erect and operate a hospital are in the nature of a charitable trust and that to subject such property to judgment and levy would be an illegal diversion and waste of the trust estate. In New York, however, this doctrine has no application to those who are not beneficiaries of the charity. The courts so held in cases in which they awarded damages against hospitals for injuries to the plaintiffs caused, in one case, by slipping on worn out linoleum and in another, by a faulty condition of a runway leading to a boiler room.

In the same questionnaire only half of the hospitals reported having either x-ray malpractice or malpractice insurance. In New York State it is a well-established rule that a hospital when maintained as a charitable institution is not liable for the negligence of its physicians and nurses in their treatment of patients as long as the hospital management has used reasonable care in the selection of these professional employees. In recent years, however, it has been established that this rule does not apply to the employees of a hospital. The liability of hospitals for the torts of its servants has been broadened recently to include claims by charity patients as well as paying patients.

All insurance companies are under the supervision of a commissioner or superintendent of insurance in the state. Insurance may be obtained to cover risks from the following various classes of insurance companies:

1. The stock company is a corporation owned by its shareholders and is the type of insurance corporation most commonly in use. It has a capital stock and underwrites risks for the public at a profit for its shareholders.

2. The mutual company is a type of membership association providing indemnity to its member policyholders at cost, including its overhead. However, all member policyholders are liable for losses should their contributions, premiums or deposits be insufficient to cover the losses adjusted. Furthermore, in the event of liquidation they stand the threat of being assessed a proportionate share to cover unliquidated liabilities.

3. The Lloyds' association is a form of joint venture in which a group forms a common pool and grants a power of attorney to a manager who operates for it with a profit motive. Since this is a partnership rather than a corporation, it does not enjoy a limited liability.

4. The reciprocal association, in effect, is the same as the mutual company except that the numbers enjoy limited liability.

Premium Rates Vary

It is important to remember that variance does exist in premium rates or costs as offered by the different types of insurance companies. For example, the stock company rates may be higher for the same type of risk offered by the mutual company. But, with the stock company, the insured faces no additional assessment or liability based upon the experience of excessive losses.

One of the most important types of insurance, and often the most controversial at time of settlement, is fire insurance. Two types are obtainable; they are classified as full insurance and co-insurance.

With full insurance the company assumes the full amount of any loss up to the face of the policy; with co-insurance the assured becomes a participant in the loss with the insurance company, according to the ratio agreed upon. Fire insurance in New York City is almost entirely written with an 80 per cent co-insurance clause. Full insurance is obtainable but it is not possible to obtain less

Abstract of a talk made by Mr. Lashins, a certified public accountant of New York City, at the New York Conference on Hospital Accounting, United Hospital Fund.

than 80 per cent coverage. In New Jersey and in other sections of New York State, however, it is possible to obtain co-insurance of less than 80 per cent.

Experience has shown that only a small percentage of fires result in total losses. In cities with good fire protection, where hazards are minimized by proper supervision by fire authorities, only about one out of every 25 fires results in a total loss, and a large percentage of the remaining fires cause a loss of less than half the value of the property. With a knowledge of this fact, many property owners are willing to carry only a small amount of insurance, pay a small premium and take the chance that their policies will be large enough to cover the average partial losses that have been found most likely to occur.

If the majority of property owners took out policies on only a part of the value of their properties, the insurance companies would be compelled to increase their rates accordingly. This would be unfair to those owners who did not wish to gamble on a partial fire loss and who insured their property for nearly full value. Hence, the co-insurance clause was devised.

The 80 per cent co-insurance clause provides that if the owner does not carry insurance amounting to 80 per cent of the full value of the property, the insured becomes a co-insurer with the company and bears a percentage of the loss even though it is only a partial one. In no case, however, even though the property is insured for 80 per cent of its value, will the insurance company pay for a loss greater than the face of the policy.

Fire insurance is a controversial type. Invariably, a difference of opinion arises on the fire loss claim between the assured and the company.

When a loss occurs, whether it is partial or total, the question of actual cash value, or the replacement value of the property as it stood just prior to the fire, is the factor. A method used in arriving at this value is that of taking the original cost plus the improvements subsequently made, less depreciation. Due allowance is also made, in accordance with the replacement clause, for any increase

or decrease in current cost of material and labor.

The stated method of adjustment may sound simple but, in fact, a number of complications arise with the query and definition of value. Market value, the courts have held, is not synonymous with cash, or replacement, value. This decision is of economic soundness, since a market value presupposes a market or sale of the property that was not intended with the issuance of the policy. Further, the fact that the property may be worth more or less in a sale has no bearing upon the utility value and the issuance thereof.

Hospitals have an obligation not only to themselves but to the public and to their benefactors to maintain and perpetuate premises and services, and, as has been stated, insurance is the best medium of protection. Yet examinations disclose that many institutions are underinsured and many are overinsured.

How can hospitals determine the proper amount of fire insurance, which in the event of a loss would assure an agreeable adjustment and provide the necessary funds to replace losses and damages?

The answer is an independent appraisal. The New York Board of Fire Underwriters looks favorably upon independent appraisals made by recognized, competent appraisers. Investigation has shown that the fee for this service is negligible, and the benefits gained far outweigh the cost. Appraisals for insurance purposes take into account the fair replacement value to the owner and do not necessarily consider resale value. In no case will values greater than reproduction cost, less depreciation, be allowed.

It is safe to assume that any valuation set up by a competent authority will be acceptable to the insurance companies. The valuation so set up is based upon competent experience and becomes the basis of the insurance coverage required.

These appraisals may safely be staggered at five year intervals. In the intervening period the normal amount of depreciation may be deducted from, and the additions, if any, added to the established appraisal. In this manner, the properties of an institution may always be insured on the basis of their replacement value.

Liability of Charities

AUTHORITIES differ on the subject of the liability of charities for the negligence of their agents or employees. Summed up briefly, the laws of New York State and New Jersey in regard to the liability of charities may be stated as follows:

First, both states hold that there is no liability to patients on the part of the hospital for the negligence of its nonadministrative officers, such as doctors, nurses, surgeons, teachers and professors, provided it can be shown that the hospital used due care in the selection of such persons.

Second, New Jersey holds that there is no liability to patients on the part of the hospital for the negligence of the hospital's administrative officers. This question is still open in New York.

Third, New Jersey holds, on the basis of the case of *Boeckel v. the*

Orange Memorial Hospital, that there is no liability on the part of the hospital for the negligence of its agents or servants to anyone with a bond of attachment for the person who is visiting the patient at the hospital. There has apparently been no case in New York State directly in point with the *Boeckel* case, but in view of the opinion of Justice Cardoza in the suit of *Schloendorff v. the Society of the New York Hospital* to the effect that a hospital is liable to strangers, that is, to persons other than patients, for the torts of its employees committed within the line of their employment, the New York courts would probably decide adversely to the *Boeckel* case.

Fourth, both New York and New Jersey hold that the hospital is liable to a stranger for the negligence of its servants and agents.

Medical Equipment on the Air

HORATIO B. WILLIAMS, M.D.

SEVERAL years ago important investigations at the Naval Research Laboratory in Washington, D. C., were subjected to so much interference from some unknown source that work practically ceased during the entire summer. This disturbance was eventually traced to diathermy machines. One machine in particular, located in Boston, was found to be the principal source of disturbance. Complaints of interference with police radio communication are becoming more frequent and more insistent, since this interference is of a serious nature, resulting at times in the crippling of an important service.

Short-wave diathermy equipment may interfere with radio communication in several ways. Radio receiving sets that are supplied with energy from the same transformer secondary coil as the diathermy equipment may have disturbance transmitted to them directly along the wires. This can be prevented by installing a suitable filter or shielded transformer in the supply line to the diathermy apparatus. If, as is usual, the service transformers are not shielded, disturbance may pass to the primary power line and thence to the secondaries of other circuits. Power may be radiated with great intensity from the line leading from the diathermy equipment to the transformer if a part of this line consists of wires run through the air on a pole line.

Radiation may occur from the short-wave generator or from the cable that leads to the patient; it can be prevented by properly shielding the apparatus and the cable. This is a problem that can and should be solved by the manufacturer of the equipment. The manufacturer should also supply suitable line filters or shielded transformers to prevent the disturbance created by diathermy equipment.

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There remains the terminal device at the ends of the cable, usually condenser plates or a coil, that supplies energy to the patient. Finally, the body of the patient may act as a radiator. The terminal equipment and the patient can be prevented from radiating by shielding the room in which treatment is given.

Shielding consists of surrounding the room on top, bottom and sides with a good metallic conductor at earth potential. Such a shield is absolutely effective against electrostatic disturbance but is only partially effective

material should be connected by soldering at frequent intervals; otherwise, sparks or local heating may set up a fire hazard. When necessary, a second shielding layer may be used. An adequately shielded installation with suitable line filters should not disturb radio communication.

Interference might be prevented by assigning certain definite bands of frequency to the medical profession. Equipment would then have to be made to operate only at these frequencies and to have no powerful harmonics except such as might fall

How can diathermy machines be prevented from interfering with radio communication? Doctor Williams makes several suggestions

tive against electromagnetic disturbance. The higher the frequency of an electromagnetic disturbance the greater will be the effectiveness of a given thickness of shielding material. Maintenance of the shield at earth potential is approximated by connection to earth but is again only partially realized; the higher the frequency the more surface must the earth connection have to be effective. A long path from the shield to earth increases somewhat the difficulty of maintaining approximate earth potential. The higher up in a building the equipment is located the more readily it radiates to a distance. From this standpoint basement locations are preferable.

The shield may be a continuous surface of good conductor, such as copper, but it will be reasonably effective if parts of it are made of wire mesh provided this has been tinned after weaving so that there is a good contact at each crossing point that will not be lost by surface corrosion. Windows and ventilators may be so shielded. All parts of the shielding

in higher ranges that are also assigned to the profession. If this alternative is accepted, however, it will result in the obsolescence of a large amount of existing equipment and will also involve providing new equipment with a control device such as is used by the communications industry to prevent variation of the frequency beyond prescribed limits. The narrower these limits are the smaller will be the encroachment of medical apparatus on the channels of communication but the more expensive will the control apparatus become. To prevent undue expense, the band at any given frequency would have to be rather broad.

There is no advantage to be gained from the medical standpoint either in control of frequency within narrow limits or in broadcasting. The communications industry will not be inclined to give up a considerable part of the available channels of communication unless technical or economic considerations definitely indicate that it is the best solution.

The expense of shielding depends

upon the size and number of rooms to be shielded and upon whether they are in an already existing building or are to be provided in a new building. In the latter event shielding may be done in such a manner as to involve little or no additional expense even if the entire building is shielded. In existing hospital buildings in which equipment is required in many rooms the cost may be pro-

hibitive. Physicians' office buildings to be built in the future might well incorporate shielding. In apartment buildings it would not be economical for the physician himself to shield unless he has a long lease on the property.

Before any large shielding project is undertaken by hospitals certain facts need to be established. First, how much can the disturbance be

mitigated by proper design of the diathermy equipment as regards shielding and incorporation of line filters? Second, can anything be done by the communications industry to render its services less susceptible to disturbance by medical equipment?

The conventional type operates with a fixed frequency that is modulated in amplitude to produce the variations necessary to transmit signals (including voice and music). Diathermy apparatus and atmospheric electricity interfere by adding to or subtracting from the amplitude. A new system of radio transmission has recently been developed that modulates the frequency and is remarkably free from extraneous disturbance. Should this system be adopted for the broadcasting of programs of entertainment, education or advertising, little if any disturbance from medical equipment would be experienced. If the same system were adopted for police communication that important channel, too, would experience little or no interference. The quality of the programs that can be realized under this system is far superior to the present conventional broadcast. When it becomes available in the near future public demand is likely to force its general adoption.

A physician's office in a city near New York has recently been shielded with continuous thin copper. Tests by engineers of the Federal Communications Commission show that this shielding is satisfactorily effective so far as interference with receiving apparatus distant three or more city blocks is concerned. If the shield is left ungrounded the protection is almost perfect even in the same house. Leaving it ungrounded, however, introduces a fire hazard. A single ground was in service when the tests were made. Theory indicates that multiple grounds symmetrically placed should result in lessening the disturbance and this is to be tried, but the data are not yet available.

It is probable that no single formula will meet all conditions. The problem is capable of solution in several ways and requires careful study to determine what is best and most economical for any given set of conditions.

Visiting Cards Are Trumps

RONALD YAW

WE FEEL that we have at last found the answer to the difficult problem of controlling visitors at the Blodgett Memorial Hospital, Grand Rapids, Mich.

We have made just one addition to the usual system of having visiting card passes issued at the information desk and inspected at the elevators. This addition is an inexpensive cellulose acetate envelope into which the two visiting cards allowed for each patient are inserted. The third card, without an envelope, remains in the rack to indicate the presence of the patient in the house. These three cards are prepared by the admitting department upon admission of the patient.

Color plays its part in two ways. In the first place, the tickets are colored to indicate the type of patient: private, semiprivate or ward. The second need for color arose when it was discovered that people would intentionally keep passes for several weeks in order to see their friends. This was eliminated by having several sets of envelopes all with different colored borders. Thus, if purple borders are being used this week and a blue bordered pass is shown to the elevator operator, she immediately sends the culprit to the information desk to make his peace.

It is interesting to note the reaction of the public to these simple envelopes. The intrinsic value of the pass is boosted to the point that vis-

itors will go to great lengths to return them. We have several mailed back to us each week. The "Oh, let them make another" attitude is gone.

Flagging passes to indicate the need for financial arrangements is also simplified. A small note tucked into the envelope warns the information clerk that the individual is wanted by the business office so that the tickets are not paper-clipped and pinned into a dog-eared state.

Cox, Mr John

Floor 4 Mens Wd

You are about to visit sick relatives or friends. The hospital is doing its best to provide for their rapid recovery. You, too, can help by making your visit exceedingly short.

Please return this card to the Information Desk as you leave. Otherwise you will deprive patients of other visitors.

SILENCE PLEASE

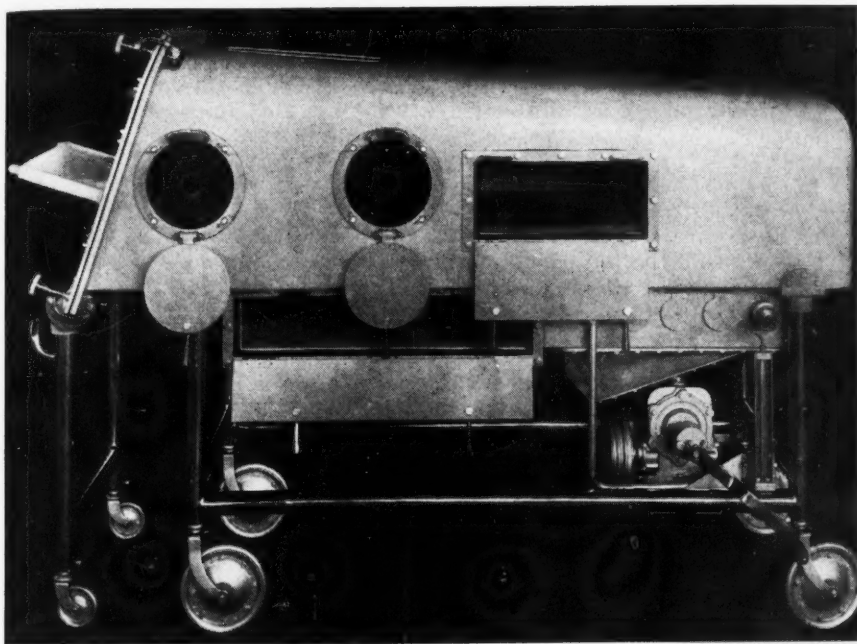
OVER

Speaking of dog-eared visiting cards, we don't have them any more. Our cards are printed on lighter paper than formerly and then are protected by the transparent envelope. Incidentally, the lighter weight paper stock makes neatly typewritten cards possible. Because our cards do not get rumpled and because they are returned to the information desk, the necessity for making new cards every few days is eliminated. All in all, we are well pleased with these transparent envelopes.

The author is assistant administrator of the Blodgett Memorial Hospital, Grand Rapids, Mich.

A Weight Off Their Chests

B. R. STEPHENSON



Left: The second streamlined respirator, showing the openings and the method of hand operation with the bellows beneath the bed. Above the manometer is a valve for adjusting the amount of vacuum. Two portholes permit attendants to give medication. The portholes are fitted with sponge rubber diaphragms that fit snugly about the attendants' arms.

RESPIRATORS for the assistance of those suffering from impaired breathing have been available for several years. The first one that used a partial vacuum and pressure was constructed by Philip Drinker in 1928. Since then several models have been developed, commonly using an iron or steel shell; hence, the name, "iron lung." These machines have varied in size from a small chest model to the giant room-size unit at the Children's Hospital in Boston. The usual size is sufficiently large for an adult, the head being supported on a head rest outside the shell.

The first respirator constructed in Buffalo, with the usual steel shell, was built in a boiler factory under my direction. When Supt. Moir P. Tanner of the Children's Hospital asked me to supervise the construction of a unit for that hospital it was decided to use aluminum to reduce the weight and to facilitate handling and moving, particularly in elevators. Other new features that seem worthy of reporting were introduced into the construction of this unit and of another one subsequently built.

The author is a physicist at the Edward J. Meyer Memorial Hospital, Buffalo, N. Y.

Right: The first aluminum respirator with adjustable head rest and diaphragm support, bedpan compartment and openings for care of the patient by nurse or physician.



A respirator built of aluminum has two principal advantages, *i.e.* lightness of weight and appearance. Corrosive resistant sheet aluminum reduces the weight. It also is easily shaped to a pleasing contour and, when given a sand blast finish, produces an attractive piece of hospital equipment.

When a respirator is to be constructed or purchased the essential features sought are comfort for the patient, dependability, quietness, ease of operation and convenience in transportation. It has been found that a respirator in which the patient's body is placed inside with the head resting outside is the only type

that satisfactorily meets these requirements.

The underlying principle of the operation is simple. Any type of equipment suffices that will produce a relatively slight intermittent reduction in pressure about the chest of the patient while leaving the nose and mouth open to atmospheric pressure. The slight excess of air pressure acting through the trachea forces air in and expands the lungs. When normal pressure is restored on the chest, the muscles contract to force the air out again, thus producing a complete respiration. Much less difference in pressure is required in this process than is required by the one

in which the thoracic cage is compressed, as in Schaefer's method or the Bragg-Paul pulsator.

The mechanism for producing the reduction in pressure can be of any type that will change the total volume of the relatively tight box by 1 part in 30. This is due to the fact that atmospheric pressure will support a column of water approximately 34 feet high while a respirator needs a reduction in pressure of less than 1 foot of water. A 6 inch reduction of water pressure is usually sufficient but there should be an excess to make up for leaks.

Some respirators use a piston type of pump, others use a fan similar to a vacuum cleaner, but the one that is most commonly employed and gives the least trouble is the bellows. The position is immaterial so long as the bellows produces sufficient change in volume, is out of the way and is so constructed that it can be driven by an electric motor, or, in an emergency, can be operated by hand.

Patients Easily Cared For

The care and comfort of the patient are facilitated by the inclusion of adequate observation windows and sufficient easily operated openings to admit the arms of the attendant without destroying the vacuum. For the incontinent patient it is often desirable to have an opening in the bed with a bedpan compartment below this opening. The neck piece must be adjustable and of such material and construction that it does not irritate the neck of the patient and, at the same time, is tight enough to ensure little leakage of air through or past it. A flat comfortable bed should be provided since these patients may lie in one position for many days or weeks.

The rate and depth of respiration should be under the control of the physician in charge. The rate is controlled by the mechanical arrangements of the motor and reducing mechanism while the depth is changed by the amount of vacuum. This necessitates an easily read and accurate vacuum gauge and mechanism that will permit the amount of vacuum to be changed at will.

Other purely mechanical features should include large casters to facili-

tate movement, quick-acting clamps for all openings, adequate illumination for the inside and an overall size small enough, if possible, so that the respirator can pass through doors, fit into elevators and be transported easily in a truck.

The accompanying photographs show the essential features of the two aluminum respirators. The bottom of the box was made of $\frac{1}{4}$ inch aluminum and the remainder of the shell, of $\frac{1}{8}$ inch aluminum welded to the bottom. The head piece and supporting ring were made of $\frac{3}{8}$ inch aluminum to prevent warping while handling since these two parts must make good contact in order to exclude air. The legs of the first unit were made of aluminum pipe but those of the second were made of chrome plated steel tubing of approximately the same strength and weight.

Two types of pumps were used: one, the conventional bellows at the end of the respirator and the other, a flap type of bellows placed beneath the foot of the unit where it is out of the way of the attendants. The leather used in the bellows is of the best grade of steer hide, which is strong and will remain soft for a long period of time. The motor to drive the bellows is of one-third horsepower acting through a 60 to 1 reducing gear and pulleys of three diameters so chosen that speeds of 16, 20 and 24 strokes per minute are available.

The bed on which the patient lies is constructed of thin sheet aluminum welded to the aluminum frame. This frame is, in turn, welded to the head piece and the whole unit is supported on separate casters, two inside the box on a track and two outside on pipe legs, to facilitate placing the patient in the respirator. A thick sponge rubber mattress is placed over this for the comfort of the patient.

The aluminum sheet has a door near the head end of the bed, which may be held open. The sponge rubber mattress has a separate section made to fit over this opening so that it can be removed and the door left open for incontinent patients. For continent patients the door remains closed and the section of pad is left in place.

A large window is inserted in the top for observation and two portholes are provided on each side so that the nurse or physician may reach in to care for the patient or to give medication. These portholes have easily replaceable sponge rubber diaphragms with small holes in the center that fit snugly about the arms of the attendants and exclude air.

All portholes and the head piece are held by quick-acting clamps so they can be opened or closed with little delay.

Pressure Read by Manometer

The pressure is read on a water manometer constructed like blood pressure apparatus. One large leg and the other small leg are calibrated to read directly in centimeters. This instrument never gets out of order nor does it have to be recalibrated after it is once installed. A non-volatile oil of the same density as water prevents loss of fluid level by evaporation.

Since reduced pressures only are desired, flap valves have been provided around the bellows to allow any air that leaks into the respirator during the vacuum stroke to escape without building up a positive pressure. If, for any reason, a positive pressure is desired these valves may be kept closed.

The two respirators shown are essentially the same, the real difference being in the appearance and the position of the portholes and diaphragm. The diaphragm, placed under the shell instead of at the end, makes the unit more compact so it can be more easily operated in transit.

These aluminum respirators weigh only 460 pounds complete, while the one of sheet steel that I constructed weighed 870 pounds. This large reduction in weight is an important factor in transporting the unit. The respirators are quiet in use, easy to operate and provide all the essentials for the adequate care of those unfortunate persons who must have respiratory assistance.

The author is indebted to Supt. J. H. W. Brower of the Hospital for Sick Children in Toronto and to Albert Derbyshire, chief engineer of the Toronto General Hospital, for many suggestions and for the privilege of examining the units made in those institutions.

Cost Control by Surgical Supervisors

NELLIE GORGAS

THE supervisor in the operating room has, in addition to her responsibility for the care of her patients, a definite responsibility for controlling costs in her department. In the University of Chicago Clinics it is felt that control by budget is one of the most important of methods; it can provide regularly and accurately to the administrator and the department head a definite measure of the control so that changes may be made before it is too late.

Accordingly, each year a budget is set up for the operating rooms in the University of Chicago Clinics

such as air conditioning or a new operating room, estimates of their costs must be taken into consideration. While it is time consuming to obtain detailed estimates for structural changes and for equipment and supplies, as well as for staff needs, hospital directors today are insisting upon knowing all the facts before making appropriations.

As soon as possible after the board of trustees has made its plans, the chief anesthetist and the nursing supervisor should be informed of the exact appropriation for the next year. From then on it is their respon-

how much the expenditures are over or under the budget pro rata at the end of the month covered by the report. These "overages" are investigated carefully each month by all concerned in the control of costs.

The costs in the operating suite are divided into the following: (1) general direct charges, including salaries of nurses, orderlies, attendants and clerks, and supplies and expense; (2) anesthesia charges, including salaries of anesthetists and the anesthesia resident staff; cost of maintenance of resident staff, and anesthesia supplies and expenses, and (3) overhead charges such as steam, electricity, repairs, housekeeping, laundry, insurance and administra-

Chart 1—Comparative Costs in Operating Rooms, 1936-1939
(For Use in Establishing Budget for Next Fiscal Year)

Account	1936-7		1937-8		1938-9*		Comments	Estimate 1939-40
	Total 3315 Operations	Per Op.	Total 3461 Operations	Per Op.				
Salaries, general	19,631.24	5.92	23,675.84	6.84	27,007.80	7.56	Salary rate increase	28,000
Salaries, anesthesia	8,401.16	2.53	6,015.00	1.74	7,366.44	2.06	Replacement to be made	7,000
Supplies & Expense, general	10,443.03	3.15	11,919.46	3.44	12,870.36	3.60	Must be reduced	12,000
Supplies & Expense, anesthesia	3,354.70	1.01	2,955.13	.85	2,409.72	.67		2,500
Maintenance of Interns	1,473.68	.45	2,321.28	.67	2,249.88	.63		2,300
Overhead	12,837.15	3.87	16,033.16	4.63	16,216.44	4.54	In departmental budgets	16,200
Total	56,140.96	16.93	62,919.87	18.17	68,120.64	19.06		68,000
*On basis of 7 months.								

after the director or his assistant has consulted with the chief anesthetist and the superintendent of nurses. The superintendent of nurses has, of course, discussed the matter with her operating room supervisor. An estimate of the appropriations needed for salaries and supplies for the coming year is made up as accurately as possible on the basis of current activities, past records of achievement and any changes in demand that can be foreseen. Comparative statements, such as chart 1, are useful as a basis for the calculations for the next year.

If new facilities are to be added,

Miss Gorgas is assistant to the director of the University of Chicago Clinics.

sibility to see that costs are controlled so that appropriations are not exceeded illogically.

A monthly report (chart 2) from the accounting office has been instituted in the University of Chicago Clinics to inform department heads and the administration of the actual expenditures for the month in each separate account and of the cumulated expenses since the beginning of the fiscal year. It also shows the amount which, according to the adopted budget, should have been spent, upon the assumption that one twelfth of the annual appropriation is to be spent each month. The last column of the monthly report shows

tion. The last named are charged on a pro rata basis as portions of total maintenance, laundry, housekeeping and administration.

Inasmuch as the items included in overhead are primarily the responsibility of other department heads, such as the engineer, housekeeper and administrator, the operating room supervisor is not informed directly of these costs each month. When one of these other department heads, however, finds the services of his department being called upon out of the ordinary, he consults the supervisor and together they try to correct the condition.

The chief anesthetist is held re-

sponsible for all anesthesia costs. The direct responsibility of the operating room is then only for the costs of general salaries and expenses. The salary appropriation is definitely allocated to (1) the individuals on the permanent pay roll of the department when the budget estimate is prepared and (2) a temporary pay roll item to cover extra help during vacations or sick leaves.

The permanent pay roll item leaves little opportunity for control; a standard amount of staff help is provided for. No extra nurses, orderlies, attendants or clerks may be added because there are definite regulations in the accounting office that, after the budget is adopted, only replacements may be entered on the pay roll, that each new entry card must show the name of an employee who is to be removed and that the new salary must be equal to or less than the old one. In the matter of the temporary pay roll, however, the supervisor may use control by replacing absent or sick staff members only when absolutely necessary.

The scheduling of duties and the policies in regard to personnel are important in controlling temporary pay roll costs. In the University of Chicago Clinics, although a twenty-four hour service is maintained in the operating suite, the normal day's work is finished by 6 o'clock each evening. After that, only real emer-

gency operations are performed. Staff members, in rotation, are on call for return for night duty. Since they live out of the hospital, taxi fare is provided for them and their time on night duty is made up at the first opportunity. Thus, an adequate staff is provided for twenty-four hour duty at a minimum of salary expenses without imposition on anyone.

Another method of controlling temporary pay roll costs is to have available elsewhere in the organization well-trained personnel who may be transferred to the operating rooms in time of need. There are practically always some requests on file from staff nurses and supplementary workers who wish to be transferred to the operating rooms. It is good practice to transfer them one by one, allowing the older operating room staff members to return to work in other parts of the hospital after about two years in the operating suite. Fully trained in the technic on the floor, these staff members are then available for vacation and sickness relief.

In the matter of supplies and expenses, the supervisor cooperates with the administration in effecting economic purchase and use of items. Responsibility for the routine replacement of supplies on the floor lies with the supervisor after a standard inventory has been decided upon by

her and the administrator and after economic purchase quantities have been set up on the basis of usage, quantity discounts and investment and storage costs. Replacement of minor instruments and pieces of small equipment is usually approved routinely by the administrator. Any change in type of instrument or other supplies, however, must be cleared with him.

The supervisor is in the best position to know the total needs of the surgeons and to obtain the cooperation of the various services in using a single item that will serve the purposes of all. She also is in a position to work with the chief surgeon and the chiefs of all services to schedule the periods assigned to each service properly so that the same items of special expensive equipment will not be needed at the same time and will not have to be carried in double or triple quantity. This is somewhat of a Chinese puzzle at times, especially in a teaching institution in which class time, out-patient clinics and research programs all must be considered. But, with diplomacy and determination, a feasible program may be devised.

The supervisor may obtain cooperation of the staff in working out a definite schedule of supplies to be provided for operations on each different service. Chart 3 shows the standard setup of both staff and sup-

Chart 2—Monthly Report on Costs in the Operating Suite
January

Account	January			July 1 to January 31			Comments
	Actual	Pro Rata	Diff.	Actual	Pro Rata	Diff.	
For Supervisor Salaries, general	2,167.90	2,683.57	-515.67	15,754.56	18,785.09	-3,030.53	Consistently under on salaries
Supplies & Expense, general	1,307.99	1,166.68	141.31	7,507.74	8,166.67	-658.93	Some of stock replenished for 6 months
<hr/>							
For Chief Anesthetist							
Salaries, anesthesia	701.00	601.50	99.50	4,297.06	4,210.50	86.56	Replacement before year is over
Maintenance of Interns	162.31	250.00	-87.69	1,312.43	1,750.00	-437.57	Conservative and cooperative staff
Supplies & Expense, anesthesia	176.92	200.00	-23.08	1,405.70	1,400.00	5.70	Cutting down overdraft
<hr/>							
For Administrator							
Total Direct Costs	4,516.12	4,901.75	-385.63	30,277.49	34,312.26	-4,034.77	
Overhead	1,341.05			9,459.59			Will show up in departmental pro rata

plies for an emergency operation. While the number of supplies is not definitely limited, because primary consideration is always given to the patient, a schedule does provide the initial setup for the routine case. It is a practice in our clinics for either the supervisor or the head nurse to see each patient personally before anesthesia is begun so that she can see for herself, from the patient's condition, what emergencies are likely to arise and can arrange to have readily available whatever extra equipment or supplies may possibly be needed to meet these emergencies.

A standard setup, too, makes it relatively easy for the staff to lose no time in finishing one operation and beginning the next. The use of an anteroom in which the anesthetic may be administered will conserve space; by cutting down the time for each patient in the operating room, more operations may be performed in a given number of rooms. Cost of maintenance of space in a hospital increases materially with each additional cubic foot, so the supervisor must make economic use of each inch.

The interest and cooperation of the staff are essential if "adequate" supplies are to mean the *least* amount adequate and economic. By watching her operating schedule day by day, the supervisor may compute certain weekly standard orders and then adjust them in accordance with the varying number of major and minor operations coming to the floor each day.

The definite allocation of specific responsibilities to each member of the staff is another method used by efficient supervisors to control costs. By repetition, one becomes so familiar with the work that it is comparatively simple, for instance, to sort out instruments beginning to need repair so that major repairs and replacements may be avoided later. Equipment, such as sterilizers, will be kept in much better condition when the worker is familiar with it and knows he is to continue to have to use it.

Equipment must also be safeguarded physically. All equipment put into use must be checked to see that it is returned in good condition to its own place and is properly locked

Chart 3—Cost of an Emergency Appendectomy

Staff: 1 operating nurse, 1 circulating nurse, 1 orderly, 1 anesthetist and 4 doctors	
2 nurses (\$105 a month) 46c an hour.....	\$0.92
1 orderly (\$80 a month) 37c an hour.....	.37
Ethylene.....	.35
Novocaine crystals.....	.225
Anesthetist.....	1.77
Laundry, 42 pounds @ \$.027.....	1.134
4 doctors' suits; 5 doctors' caps (1 for orderly); 3 nurses' dresses; 3 nurses' caps; 8 masks; 1 lifter; 2 pillow slips; 17 towels; 5 large sheets (stretcher and table); 2 lap sheets; 1 table pad; 2 small sheets; 5 glove towels and envelopes; 5 gowns; 6 lap sponges; 1 blanket; 1 tray cover; 1 large bag; 2 small bags; 2 large wrappers; 1 small wrapper.	
5 dozen sponges @ \$.008 each.....	.48
5 tubes, catgut @ \$.19 each.....	.95
Skin silk.....	.10
3 knife blades @ \$.125 each.....	.375
Iodine, 60 cc.....	.052
Alcohol, 250 cc.....	.087
	\$6.813
For Preparation (cleaning and setting up)	
2 nurses (one hour).....	.92
1 orderly (half hour).....	.185
1 attendant (half hour).....	.155
	\$8.073

Not included: Gloves (mending and preparing), needles, repair of instruments, replacement of new equipment, head nurse and supervisor, making of supplies, packing drums, wrapping packages, solutions.

up in one of the cabinets to which the supervisor should have the only key. A monthly physical inventory should be taken.

Month-by-month conformity of actual expenditures and the budget pro rata cannot always be expected. A cumulated figure as the months go on is more reliable. Rightfully, if the departmental work is at all seasonal, the total budget appropriations should be apportioned on the basis of a seasonal index. Otherwise, when the peak load comes late in the year, one may unexpectedly find that, although expenses have been running consistently within the limits, they will leap suddenly above the pro rata and may even bring the total for the fiscal period so high as to make it impossible to come out even for the year.

A large bill for a special item of equipment may send expenses above the pro rata. This cannot be taken too seriously because when the special expense has ceased and the normal rate of expenditure is resumed, the "overage" will eventually iron out and, before the year is over, total expenses will be within the appropriation.

This is the case as shown in chart 2 in which anesthesia salaries are more than the pro rata. During the first part of the year, there have been on

the pay roll a high salaried anesthetist and a junior one in training to replace her. The junior will receive some increase in salary and will be replaced by an intern without salary. Hence, the monthly pay roll will be considerably less during the last few months of the year and the total will approximately equal the estimate for the year.

The administration holds the supervisor responsible for helping to locate the reason for any excess in expenditures over pro rata and for correcting it, if it is within her province, or for giving the administration complete data, if the cause is something beyond her control. This may be an increasing demand for service or an epidemic of illness. The administration may have to have the appropriation increased to cover the revised estimate; or it may be able to eliminate the excessive demands, to institute better health service or to improve certain of its purchasing procedures.

No matter what course the administration takes to remedy the situation, it is obvious that without the specific data as early as possible in the proceeding, control of the situation may be lost to a serious extent. It is obvious, then, that the supervisor is essential in the program of control of costs in the surgery.

The Patient Comes—and Goes

JOSEPH C. DOANE, M.D.

THE first contact with a new patient is made either in the admission office or, if the patient is not ambulant, in the receiving ward. Frequently, the admission is precipitated by a street accident and the patient is transported in the car of a passerby or in a police ambulance. In such cases it is important that the accident ward physician be drilled in the necessity of making immediate note of the name and license number of the person presenting the patient. This information is frequently useful in establishing the identity of the person responsible for the accident.

It is the duty of the admission clerk to ascertain promptly whether a new patient is known to the hospital as a former patient. It is necessary to obtain such information immediately to prevent duplication of laboratory, x-ray and other expensive studies that may have been carried out only a short time prior to the day of admission. If the patient is known to the hospital, a slip is immediately sent to the record keeper which requests that the previous charts be sent to the floor to which the patient is to be admitted. In some systems, the head nurse of each department is expected to request the forwarding of old charts from the record room on the receipt of a new patient. This plan is not as efficient as one in which such notifications are promptly and routinely made by the person who first contacts the patient.

Accurate Data Essential

The data on the admission sheet of the patient should be as accurate as possible. Properly spelled names and properly stated ages, references and addresses are likely to be of future legal importance. Life insurance and accident policies are often long delayed in payment because of an inaccurate recording of such facts on the patient's chart. No one but the admission clerk should make any alterations in these data after they have been recorded.

Often an inefficient institution will permit admission practices to slow

up on week ends or holidays to the extent of working distinct discomfort or even actual harm to the patient. If a patient is being transported by ambulance, the ward should be notified that the hospital is sending out for a patient who soon will be admitted to this division. If a patient is receiving emergency treatment in the accident ward, the department to which he eventually will go should be informed of the probable time of his admission.

Technic of Handling Patients

A receiving ward that becomes too routinized is likely to overlook the necessity for the prompt notification of relatives, the family physician or business associates of an accident victim who is brought to the hospital for care. If the patient is unconscious, a nurse or physician should immediately search for identification papers. It is the definite responsibility of the hospital administrator to maintain a high degree of efficiency and of understanding of the psychology of injured patients and their families. In one hospital, classes are held from time to time in which the technic of handling the accident patient and his friends and relatives is fully discussed.

In most institutions, certain administrative procedures are performed in the receiving ward before the patient is dispatched to another department. Clothes are removed, listed and prepared for sending home or for storage in the hospital clothes room; admission baths are given and valuables listed. A brief history is taken and certain emergency steps are carried out. Treatment consists largely of the administration of blood transfusions in serious accidents and the treatment of shock and of various types of poisoning.

When the physician in charge of the department decides that the patient is able to be moved, he is transported by stretcher, usually under the control of the receiving ward, and a receipt for the patient is obtained from the nurse in charge of the service to which he is assigned.

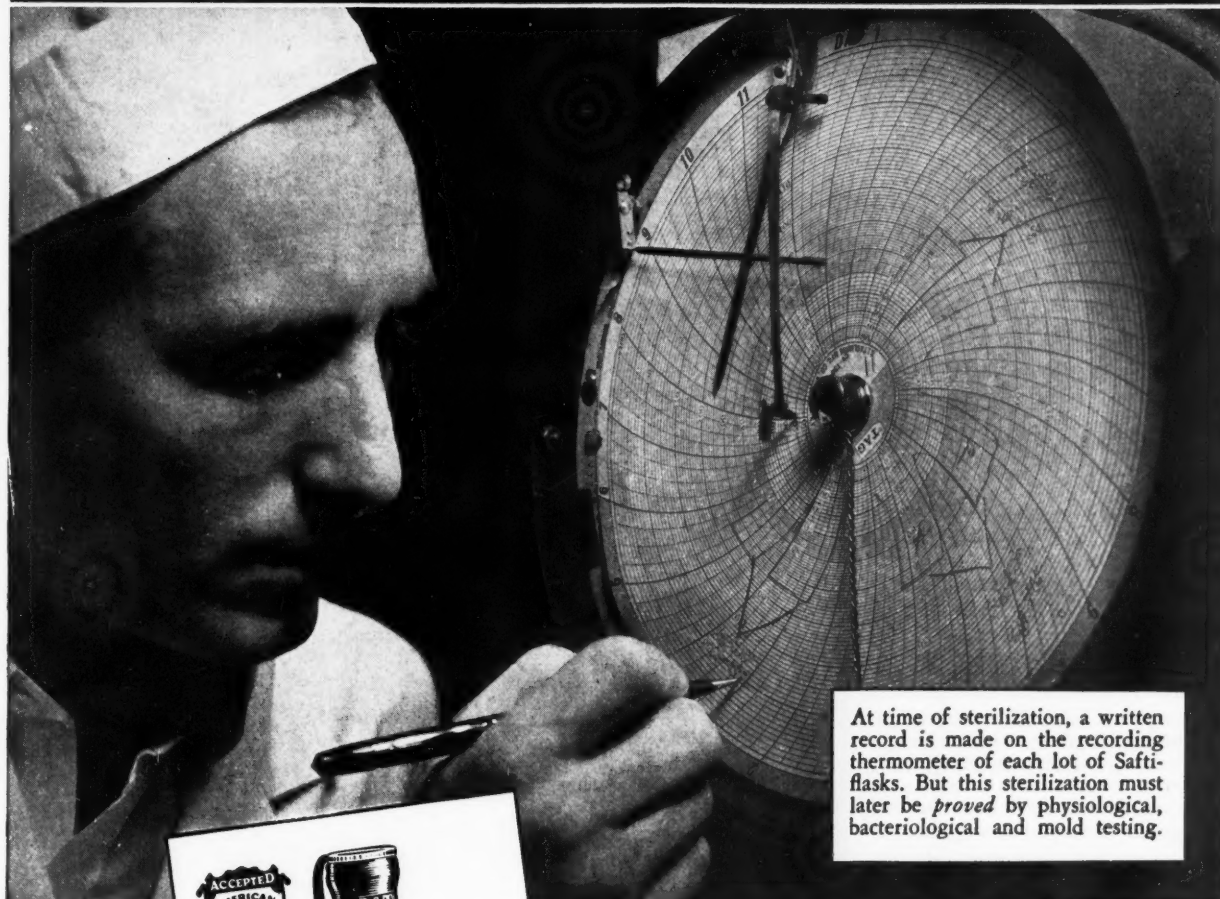
The arrival of the patient in the ward should automatically start the machinery of diagnostic and therapeutic treatment. No delay should be countenanced. If a physician is absent from his service for any reason, others should immediately assume the responsibility of beginning the patient's study. The visiting physician should provide his intern with a set of written instructions covering the laboratory and other studies permitted before he has seen the case. Here the medical procedure book finds its greatest use. It is improper to permit interns immediately to order x-ray or laboratory studies unless the case presents emergency features that contraindicate delay. It is easy to draw up standing orders that cover the study and treatment practices permitted in various types of cases. It is unfortunately not the custom to practice strict definition in these matters; the intern is too often permitted to decide what should be done without conference or previous advice from his chief.

Instructions to Staff

It is necessary to set down in bulletin form just what the young intern and nurse shall say and do when they encounter a new patient. The actual words that are employed in early introductions are as important as those that the telephone company insists that its operators use. Moreover, a word of cheer frequently possesses much greater therapeutic value than any medicine.

The patient's records should be completed within the first 12 or 24 hours. An orderly approach to early diagnostic and therapeutic practices will make it possible to present a properly worked up case to the visiting physician on his arrival without resorting to emergency orders. The term "emergency" as employed in regard to the patient is often not truly explanatory of the sick man's condition. Emergencies do occur but often such situations arise because of the forgetfulness or of the poorly planned work program of the house officer. Sometimes even the desire of the surgeon or of the physician to fit the study requirements of the patient

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into his own appointments creates the so-called emergency.

The statements that have been made regarding ward patients apply in a large measure to private patients. Before a patient reaches his private room a thorough housekeeping inspection is highly important. The presence of a few flowers on the dresser and of a complete set of information folders and the inspection of bed linen for cleanliness and freedom from stains pay good dividends.

Frequently the admission office informs the dietitian that a new patient has reached the private floor. A prompt visit by a representative of this department is pleasing to most patients. If this is not done and the food dislikes of the patient are not learned, a badly planned initial meal is likely to upset the patient's whole stay and to convince him that the hospital is inefficiently run.

A visit by the chief resident physician or the chief nurse within the first 24 hours is another pleasing touch. The floor nurse should acquaint herself with the type of newspaper the patient desires and learn of any visitors that particularly should or should not be admitted, as well as of any other details that might add to the patient's comfort. The importance of these early contacts cannot be overestimated.

Privacy for Patients

The psychology of all those who come into contact with private patients should be that privacy is to be as carefully respected in a hospital room as in the home; that friendliness, but no familiarity, is to be shown, and that gossiping is to be discouraged. Of particular importance is the observance of such little niceties as remaining at attention when in the patient's room, of never sitting down or lounging against the wall or bed and of refraining from joking or from reference to any physical characteristics of the patient.

In no department is it more important for the house officer to know explicitly the physician's desires and routines than in the maternity department. The obstetrician should be notified promptly of the arrival of the patient. For the sake of completeness and because every hospital division is equally affected, the greatest safeguard against the transmission of infection or contagion

within the hospital is the thorough inspection in the receiving ward of the patient's body for rashes, exudates and other signs of communicable disease. Usually, maternity patients are excluded from passing into the hospital by this avenue.

Much time can be saved by insisting that orders are followed implicitly and by treating each patient as if no other day would ever come. The "tomorrow will do" psychology is responsible for errors that result in the loss of service to the community and in a real increase in expense to the patient and the hospital. It is impossible to ascertain the aggregate number of days lost throughout the field by just such carelessness.

The formal discharge of the patient is the hospital's final responsibility. Many hospitals permit discharge from the wards at only two stated hours during the day. These are usually 10 a.m. and 2 p.m. Strict observance of discharge hours increases efficiency, prevents wasting the nurses' and interns' time and allows the deliberate preparation of the patient for leaving the institution.

Occasionally a physician or surgeon will refuse to discharge a private or semiprivate patient who has not paid his bill. A hospital patient cannot legally be deprived of his liberty even for an hour; those who are informed of their rights will soon obtain habeas corpus papers that force the institution to discharge them.

The last impression made on patients by the hospital staff is often one that they do not easily forget. The floor nurse who makes it a rule to wish the patient a continuing improvement in health; who suggests that she take her flowers home, and who sees the departing patient to the door or assists her into her car will often make an enduring friend for the hospital. The receiving ward which, as far as the patient is concerned, is now a discharge ward, may perform valuable last minute services, such as ascertaining that the patient has his medicine, that he has been given his diet, that he has car fare and that his clothing is suitable. Moreover, it is advisable for a nurse to make certain that relatives have been informed that the patient is coming home and for the physician to make one last physical checkup. In a properly planned institution,

the central clothes room is adjacent to the receiving ward. The advantages of this system are obvious. The importance of the centralization of effort, the prevention of theft of institutional property and the possibility of making clothing presentable by pressing need mention. In one community, residents know when an individual has been in the hospital because of the untidiness of his appearance. A pressing service is not an extravagance to the hospital and it pays dividends in appreciation.

Purchasing Credit

The credit standing of the hospital is extremely important and valuable. It has either a favorable or an unfavorable psychological effect on patients, medical staff and the community as a whole. This credit standing depends largely upon how wisely and judiciously the funds available are spent, regardless of the source from which they were derived. Although purchasing policies vary in small hospitals according to size and control, it is the administrator's duty and responsibility to set up and to maintain a purchasing system that will ensure efficient buying and ample stock supplies.

It is obvious that if expenditures are carefully made and good value is received for every dollar spent the hospital will be able to provide greater service to patients at lower cost. In small hospitals, in which purchasing agents are out of the question, all orders should be approved by the administrator as to product, amount, price, discount and specifications, if any. This system does not eliminate the possibility of delegating purchasing power to competent department heads if desired. It simply means that all requisitions must be approved by the administrator.

Untold thousands of dollars are lost annually to hospitals by not utilizing the savings available by contract purchasing of such items as surgical supplies, rubber goods (particularly gloves), drugs and soap. Likewise, thousands of dollars are lost annually by purchasing cheap merchandise. Low price alone does not always indicate wise buying.—*O. K. FIKE, managing director, Grace Hospital, Richmond, Va.*

Hospitals and the Health Program

MICHAEL M. DAVIS

BUSINESS men and others who are hospital trustees are desirous that the voluntary hospitals shall continue their services to the rich, to the middle classes and to the poor in accordance with their fine traditions. Undoubtedly it is the very success of American hospitals that has created the present active demand of the general public for more hospital service and the inclusion of hospitals in the National Health Program, which was laid before the public a year ago, and before Congress in February of this year.

The National Health Program starts with prevention. It recommends that the present powers of medicine be used to prevent disease more fully than is now the case. Only a small proportion of the counties in the United States, outside of the large cities, have effective health departments. Tuberculosis, infant mortality, syphilis, malaria and other diseases have been substantially reduced, but they are still unnecessarily prevalent among certain sections of the population and can be further lessened by the application of known methods. To extend public health work for the prevention and control of disease, to reduce maternal mortality and to promote health education and the better care of children are the aims of the first section of the program.

Sickness Compensation

Another main point is to provide, through insurance, compensation for employed workers covering part of the wage loss resulting from temporary illness as distinguished from illness causing long-term or permanent disability.

The program recognizes that a considerable proportion of the population has an income too low to pay sickness bills and that for many other

Doctor Davis is chairman of the Committee on Research in Medical Economics, New York.

self-supporting persons the uneven and unpredictable costs of sickness are a serious burden and a cause of distress and dependency. Hence the program proposes the extension of methods of paying for medical care through taxation or insurance, which spreads the cost of illness over groups of people and over a period of time.

In all these parts of the program and in the two parts relating specifically to hospitals, which will be described in more detail, the program looks forward to action by local, state and federal governments and by voluntary agencies to bring about the desired results. The bill introduced into the last Congress by Senator Robert F. Wagner dealt only with federal action and could be effectuated only through subsequent action by state and local governments and through the participation of the medical and allied professions, voluntary hospitals and other agencies.

Grant-in-Aid Plan

The method of federal action proposed was aid to the states in proportion to their respective populations, their financial resources and their special health needs. This grant-in-aid method has been used for years on a small scale by the U. S. Public Health Service in helping the states and localities with some financial aid and with technical assistance to extend and improve health departments. Owing to the wide divergences among the states in wealth and in medical and hospital facilities, the grant-in-aid plan must be flexible if it is to help most where help is most needed.

Any plans for general medical care necessarily include hospital service. The National Health Program includes provisions toward the more adequate current support of hospital

care and also toward the construction or improvement of hospital facilities where needed.

So far as hospital maintenance is concerned, enlarged government support of hospitals must be viewed in the light of the already existing use of tax funds for this purpose. The majority of our general hospitals and approximately two thirds of all general beds are nongovernmental, *i.e.* are voluntary nonprofit or proprietary hospitals. Our state and local governments and, to a small extent, the federal government are now paying voluntary hospitals about \$30,000,000 annually for the care of persons for whom these various branches hold themselves responsible. The greater part of this sum comes from city and county governments. A minority of these are supporting their own general hospitals. The voluntary hospitals derive the larger part of their annual income from paying patients, the sums received by them from taxes being a little more than what they obtain from philanthropic individuals and organizations. Endowment income to the voluntary hospitals is an additional \$15,000,000 annually, but is concentrated in a few institutions.

Extension of Existing Plans

Federal funds, such as would be made available under the provisions of the Wagner Bill, for a general medical care program would mean an extension of these already existing plans, with presumably larger funds available in places that require them and new funds available in places that now have little or nothing with which to support hospital care for the needy.

Voluntary hospitals at present have an average of about 80,000 vacant beds; approximately 40,000 of these

could be kept filled if funds were available to meet the cost of caring for persons who cannot pay their own way. These 40,000 beds, however, would not cover the need for hospital care in many communities and sections of the country.

The National Health Program would furnish federal funds to aid those states that see fit to extend their existing tax-supported plans for the medical care of needy persons and also to states that establish plans to aid self-supporting persons of small means to meet the costs of medical service through a system of health insurance. Such general plans of medical care, supported either by taxation or by contributions to an insurance fund, would affect all hospitals. The demand for hospital service would undoubtedly increase among the people and funds to support hospital service would be enlarged.

One of the chief problems is the manner in which a state and local system of general medical care, including hospitalization, would be administered. The voluntary hospitals would be involved, as they are now, in the communities and states in which public funds are paid to these hospitals. Patients paid for by health insurance funds would be a new or enlarged category. Conditions, needs and resources vary widely in the several states. Hospitals will be directly affected more by state than by federal legislation. This is at once a safeguard and an element of confusion.

A larger dependence on either taxes or publicly supervised insurance funds would bring voluntary hospitals into closer relations with local, state and federal governments than they are today. Would these relations embarrass administration and lower standards? An answer to this question must be found by working out satisfactory principles and procedures of relationship with governmental agencies during the next few years.

An important section of the National Health Program outlines the need for additional general hospitals, especially in rural areas, and for an increase in general hospital beds in a good many communities during the next decade. Federal aid to the states for hospital construction is projected in the Wagner Bill and in other pro-

posed legislation according to three methods that are not mutually exclusive: (1) a grant-in-aid plan, (2) a plan similar to that of the Public Works Administration and (3) the plan of long-term financing made familiar by the housing programs.

During the last few years a certain amount of new hospital building has taken place under "public works," but the conditions of public work programs make it difficult for the poorer states, and particularly the poorer rural areas, to undertake projects. Careful state-wide surveys that would show where need exists for new hospitals would probably reveal that these needy areas are just those in which resources to build and maintain hospitals are least available. Either the grant-in-aid plan or long-term financing on easy terms is necessary if such communities are to have and to maintain satisfactory local hospitals. Arguments that a few

centrally located hospitals can, by adequate ambulance service, meet all needs of rural areas will not satisfy the demands either of local medical practice or of the farm people themselves.

Since the World War increasing attention has been given to medical needs, medical costs and medical organization. Hospital service has been an enlarging part of this picture. In 1938, many issues emerged from the technical to the political arena since it then became apparent that public action to meet various needs was beginning to be demanded by many millions of people. This likelihood of public action brings opportunities as well as difficulties to hospitals. The more coolly and realistically that needs, methods and new proposals are studied locally and nationally by hospital governing authorities, the more likely are difficulties to be surmounted and opportunities realized.

WHAT THEY ARE SAYING

Group Medical Practice

• Education has not kept pace with intellectual demands on the medical profession and will not under the present medical system. Under the influence of science, medicine has been so transformed that no one man can hope to possess, much less to exploit, all the knowledge and skills which its practice requires. Differentiation and specialization have become inevitable. But the more highly differentiated and specialized medicine becomes, the more essential it is to find machinery for its coordination. In this respect, group practice, properly orientated, should have a particularly beneficial effect.—*JOHN P. PETERS, M.D., professor of medicine, Yale University, before the first annual convention of the Group Health Plans, under the auspices of the Bureau of Cooperative Medicine.*

Voluntary Associations Vital

• We tend more and more, in the face of the great disasters of these later years, to look to the state to supply all of our needs, but in a democracy the state is but ourselves, and the American state is founded on public opinion. The aid that it extends is based upon the support of the public, and it would be a sorry day for America if the right and privilege of voluntary association for aid to the unfortunate were ever surrendered wholly to the agencies of

government, whether these be municipal, state or national.—*HENRY NOBLE MACCRACKEN, president, Vassar College.*

Advice to Doctors

• Administer the tuberculin test to every one. One physician can give the test to several hundred persons in an hour. Not more than half of the population is sensitized to tuberculin. Therefore only 65,000,000 persons or less would need to be retested annually.

Make x-ray films of the chests of all reactors approaching and beyond adolescence.

Make complete examinations of all whose x-ray films present shadows that might be due to tuberculosis in order to arrive at the true diagnosis.

Arrange for an adequate number of beds in public and private hospitals and sanatoriums so that all persons who have tubercle bacilli in the sputum which cannot be eliminated quickly can at once be removed from their homes. Establish the strict technic for communicable disease. It is as important to protect hospital personnel as it is members of the patient's family.

Keep under close observation all who have tuberculosis lesions the progressiveness of which cannot be determined at once.—*J. ARTHUR MYERS, M.D., department of preventive medicine, University of Minnesota.*

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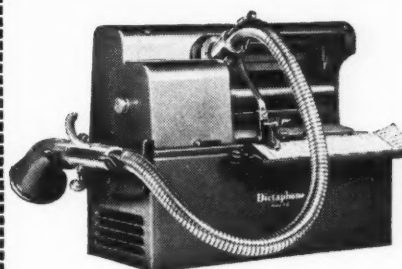
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Laundry Spends to Save

FRANCIS J. EISENMAN, M.D.

AN INCREASE in bed capacity over a period of two years was seriously taxing the laundry department of the Garfield Memorial Hospital, Washington, D. C. The situation finally became so acute that it was a physical and mechanical impossibility to meet the increased demands for clean linen and to maintain the desired standard of quality.

Regardless of how urgent a need may be, however, action must sometimes be deferred for lack of funds. Upon first consideration, this seemed to be the case at Garfield Memorial Hospital. Nevertheless, it was decided to investigate the feasibility of somehow solving the problem of insufficient laundry capacity.

The laundry advisory service offered by one of the large laundry machinery manufacturers provided a means for establishing just what

could be done to correct the situation. A survey revealed that the capacity of the laundry department could be expanded and at the same time costly overtime could be eliminated. It also disclosed that the resultant savings in productive labor would equal the cost of the modern, more productive equipment needed. With these facts established, the recommended new equipment was installed.

A new 8 roll flatwork ironer replaced the previous 6 roll ironer. With the old ironer eight girls, working forty-eight hours per week, were required to iron all the flatwork used by the hospital. Owing to the ability of the new machine to do an improved quality of work at a higher speed, seven girls are now doing all the work in a forty-four hour week.

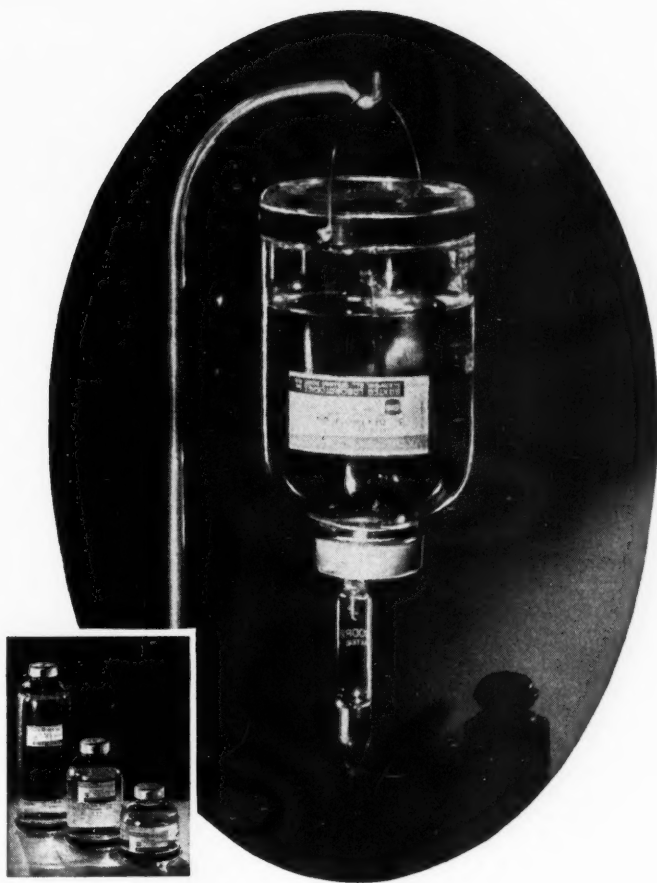
Eliminating one girl from the flatwork ironer crew and saving four

hours per week each for the remaining seven operators have resulted in a total saving of 76 labor hours per week. At the wage rate of \$14.50 per week, this amounts to a saving of \$22.90 per week, or approximately \$100 per month. As the survey had indicated, the labor saving alone takes care of the payments on the new flatwork ironer. In addition, the reduced number of working hours has resulted in lower machine operating expense. Furthermore, the speeded up schedule has made it possible to return linens to service faster. This will eventually result in a reduced linen inventory.

The increase in bed capacity had necessitated additions to the nursing staff. Consequently, there were more nurses' uniforms to be laundered. The volume of these uniforms had reached 425 per week, in addition to interns' white coats and trousers and

Doctor Eisenman is superintendent of the Garfield Memorial Hospital, Washington, D. C.





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aids' uniforms and aprons. At the time of the survey, these garments were being ironed on six large foot-operated presses. Two girls were operating the presses and, because of the large amount of hand ironing on the nurses' uniforms, five hand finishers were required after pressing. The seven girls were working a forty-eight hour week to turn out the weekly volume of pressed work.

Following the survey, the six foot-operated presses were replaced with fast operating air-driven presses. The new presses are grouped in two units of four each. The nurses' uniforms are finished on one unit and the rest of the garments are done on the other.

In the nurses' uniform unit, two girls operate the presses. One girl operates two large presses with 51 inch tapered bucks. The same girl also does the sleeves of the uniforms on a sleeve form. The other girl operates two small presses with dou-

ble-convex, oval shaped bucks. She presses the small, intricate parts of the uniforms. Because this work that formerly had to be done by hand is now done on the two small presses, only one hand ironer is needed in this unit.

The other unit also consists of four presses. Two of the presses have large rectangular bucks, 55 inches long. The other two are small presses with bucks slightly larger but similar in shape to those used in the nurses' uniform unit. To allow sufficient drying time for the heavy white coats and trousers, one girl operates all four of these presses. Again, because the small presses finish most of the parts formerly ironed by hand, there is only one hand finisher in this unit.

The result of the installation of the new air-driven presses, properly selected and most efficiently arranged in units, is that only five girls are required. Three press operators and

two hand ironers now produce more work in less time than two press operators and five hand ironers formerly did. In addition to the aprons, nurses' uniforms and interns' coats and trousers, they now press approximately 500 pieces of underwear, formerly finished on the flatwork ironer. The five girls now do this greater volume of work in forty-four hours per week, instead of forty-eight as was required with the seven girls on the old presses.

Here again, in the press department, the saving in productive labor is more than sufficient to pay for the new equipment. The elimination of two operators and the four hours per week reduction in working hours for the remaining five girls amount to a saving of approximately \$35 per week. This saving of \$140 per month will soon pay for the new presses. After the new equipment is paid for this saving will be in the nature of pure profit for the institution.

Communicating Good Will

LEWIS E. JARRETT, M.D.

AN EFFICIENT system of communications is probably more important to a hospital than it is to any other organization, owing to the number of emergency calls as well as the type of work involved. A good telephone service and an efficient method of locating people are closely related and expert planning is required to produce good results.

About three years ago it was recognized at the Medical College of Virginia in Richmond that all of the communicating systems were about as inefficient as possible. The telephone service was a source of constant complaint and the coded chime paging system was most unsatisfactory. At that time plans were being formulated for several new buildings, including a new hospital to replace the antiquated one then occupied, and it was decided that an exhaustive survey and study should be made for future developments.

The administration, therefore, en-

Doctor Jarrett is superintendent of the Hospital Division, Medical College of Virginia, Richmond.

gaged G. R. Willet of Chicago to make such a survey and subsequently retained him as consultant in our communication problems.

The changes in equipment and technic that were effected have had phenomenal results in the last two years.

Not surprisingly, it was found that the switchboard, which had been in use for more than twenty years, was antiquated. Moreover, the operators were devoting about half of their time to secretarial work, which left them little time to give efficient telephone service. Furthermore, the switchboard was located in the busiest lobby of the hospital and was too accessible to patients and visitors.

Our first move was to plan a new switchboard room in an isolated place on the seventh floor of the clinic building. A new multiple type of switchboard was installed in quiet, peaceful surroundings. On a multiple board each call is flashed in front of every operator and the first one who answers the call cancels the signal in all other positions.

Subsequently, a new listing in the local telephone directory facilitated service by our operators. We then published our own telephone directory for all inside telephones and with these improvements we now feel that we have as perfect a telephone service as it is possible to attain. The comments of the staff and the public corroborate this.

When the secretarial work was taken from the telephone operators, it was necessary to handle this service in another way. The problem was solved by installing a teletype system. This is a specially constructed desk at which are handled: (1) all requests for doctors, from inside and outside the hospital; (2) calls from doctors registering in or out; (3) all paging of doctors; (4) all reports on conditions of patients; (5) ambulance calls, and (6) other information requested by people outside the hospital.

Lines from the main switchboard terminate in a multiple key cabinet in front of the teletype, which is standard equipment with all telephone companies. This installation allows the teletype operator to answer the calls in rapid succession.

THE **CubINETte** HAS PROVED . . .
A SELF-LIQUIDATING INVESTMENT
IN THE MILWAUKEE HOSPITAL



View Showing Installation of CUBINETTES in Actual Use in the Nursery of The Milwaukee Hospital, Milwaukee, Wis.

**It Minimizes the Possibility of Cross-Infection
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and Greatly Improves Present Nursing Technique**

● As a preventive measure against the introduction and spread of contagion within the nursery, The Milwaukee Hospital, early this year, purchased 18 CUBINETTES. In a short space of time, after this equipment was put into service, its practical application to the well-being of normal, full-term, newborn infants became so generally accepted by attending obstetricians and prospective parents that the demand resulted in these units being reserved for months in advance.

A NEW SOURCE OF REVENUE

Coupled with the demand for this equipment has been a willingness on the part of parents to pay an additional fee—which, while a nominal charge, has been sufficient to place this investment on a self-liquidating basis. As a result, the hospital has ordered 12 additional units to meet the demand.

The experience of The Milwaukee Hospital is typical of the results that may be safely anticipated in every installation

of this equipment. Not only does the CUBINETTE minimize the possibilities of cross-infection within the nursery by providing individual isolation—it also maintains the proper body temperature of the infant by a thermostatically controlled heating unit and assures an automatic, uniform flow of clean filtered air without draft. In addition, it is of sufficient size to permit full care—except breast feeding—as well as storage space for individual nursing accessories.

With all of these advancements, the CUBINETTE is so compact that it requires approximately the same floor area generally devoted to a single crib. Its baked-on enamel steel and shatter-proof glass construction makes it highly sanitary.

WRITE FOR SELF-LIQUIDATING FINANCE PLAN

Our convenient payment plan will place this equipment in your hospital and enable you to pay out of the extra revenue it creates. Write for detailed information.

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Left: The telepage operator is busy registering doctors in and out as well as furnishing information about the patients. Below: The soft-voiced teletone has proved satisfactory as a means of locating the doctors.

Spaced in a semicircle within easy reach of the operator are 300 facilities for registering doctors in or out and for recording receipt of calls in their absence. This system allows a physician to register in or out from any telephone in the building or buildings. If he has a call, he can depend on the operator to give it to him when he reports to her and in this connection she becomes his "secretary."

Directly below the in and out panels are built-in card files with space for 1200 cards. Here are kept records of patients' conditions, doctors' locations, operating schedules and office and residence telephone numbers. An electric clock is installed directly in front of the attendant for her convenience. Bulletin space is provided for special and permanent information and shelves and drawers are conveniently placed.

We have developed a special card for the telepage that has space for all necessary information concerning the patient as well as for keeping a record of his condition. It is extremely practical and easy to use. Columns are provided to record the condition of the patients four times a day for four weeks, as well as a column to note the operative date.

The telepage operator by a code checks the patient's condition four times a day but changes the card only as the condition changes. As an added precaution a red celluloid tab is attached to the card of each patient whose condition is serious. Some hospital administrators will



immediately raise an objection to this system or to any other system that uses a central desk for giving out information on patients. They prefer that the floor supervisor or clerk have this responsibility. I have never had experience with the latter system but can testify to the efficiency of the telepage. It seems to me that the decentralized system would be much more expensive and would result in giving out too much information.

Our present building is so arranged that it is not practical to have the ward clerks give out information, but in the new institution now under construction this will be possible. It will be interesting when we occupy the new building to try both systems and to make a comparison as to costs and efficiency.

Our attempt to page through a coded chime system gave poor results. The codes were confusing to

a number of people, disturbing to patients, inelastic in their uses and generally unsatisfactory. We discussed the various systems available and made observations in many institutions. It was immediately decided that no coded sound system would be installed, which left only the light system and the spoken voice. The light system was soon ruled out because of the staff's dislike of any type of code system. This left only the loud speaker system with the spoken voice calling for the person desired by name.

The microphone for the system was installed at the telepage desk for the attendant to operate. The amplifier was installed in the basement immediately underneath the telepage. It was felt that the speaker itself must be as perfect as possible to eliminate the complaints encountered at many of the institutions observed. We also felt that a sufficiently large number of speakers must be used, at low volume, to obtain good coverage without unpleasant results.

The best speaker possible was selected. It is of cast aluminum painted in any color desired and the tone is soft, clear and directional as compared with the older types of speakers. It is two-sided, allowing it to be placed in the middle of the area to be covered, and permits sound to travel in both directions with a quarter of the volume of the one-sided speaker. A tamperproof volume control is built into each speaker so that the volume can be adjusted as the needs are apparent.

This entire system of communication has been a revelation to most people and has been a source of great satisfaction to the administration as well as to all other members of the hospital personnel. The time required to locate staff members has been reduced from an average of twelve minutes to an average of one minute and fifteen seconds.

The system is elastic enough to call people who would not be included in any type of code system. An accurate record is accumulated of staff attendance, and staff members actually register in and out for fear of missing a message or of not being paged since no staff member is paged under any circumstances unless he has registered in at the telepage station.

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What Causes Linen Loss?

J. G. CHARLE

MANY hospitals that employ the latest methods of efficient management for the protection and upkeep of their physical equipment seem to be content to accept as unavoidable a continuous shrinkage of their linen stock. Since the circulating linen stock of even small hospitals represents an investment of several thousand dollars, which is augmented yearly by additional purchases, the necessity for keeping this shrinkage at a minimum deserves the same amount of attention that is given to like investments.

What are some of the most common abuses that cause linen loss? We may take it for granted that the "human element" is chiefly responsible for the destruction of linens and that no system of linen control will eliminate this factor. In other words, a prime cause of linen losses can be charged directly to the handling of articles by employees who are careless and negligent merely because these objects are the property of the hospital instead of their own.

Rigid Control Needed

This type of carelessness is not likely to be discouraged by a system of linen control, but only by close supervision and a rigid routine that does not overlook even the smallest details pertaining to the preservation of the hospital's linen investment. The most valuable contribution to that end must come through the close cooperation of the nursing department with the department in charge of linen control.

The only hope for an effective remedy is an understanding of the abuses that cause shrinkage in linen inventories and correction by the enforcement of regulations, which often

Mr. Charlé is in charge of maintenance, Beth-El Hospital, Brooklyn, N. Y.

may appear to be unadulterated red tape to the employees concerned. Rare indeed is the hospital in which the nursing and housekeeping or laundry departments see eye to eye in that respect. Whenever they do the resulting saving is by no means negligible.

Common Causes of Loss

The following are a number of the more common causes of linen destruction, all of which are curable by the enforcement of routine regulations.

1. *Tearing linen for cleaning and dusting rags.* This is usually done by nurses who claim that rags were not to be found on their respective floors. To avoid this, two rag bags should be kept on every floor or ward of the hospital, one for clean and one for used rags. The used rags should be sent daily to the laundry department to be changed for clean ones. The nurse in charge should be responsible for the continued supply of rags.

2. *Tearing linen for the use of sterile covers in operating and delivery rooms.* To avoid this a sufficient supply of covers for all departments that handle sterilization of linen or instruments should be on hand.

3. *Tearing bed linen in dormitories, generally to cover ironing boards.* This practice should be mentioned in the regulations regarding the use of dormitories and offenders made to pay for damages.

4. *Tearing linen by using pillow cases and sheets for hamper bags.* Supervision by floor supervisors or charge nurses will prevent this.

5. *Tearing bed linen by catching it on bed springs.* Supervision and ordinary care in making beds will save the linen.

6. *Cutting the sleeves of pajamas*

or gowns before starting an intravenous injection. Patients' arms should not be placed in the sleeves, when notice of an intravenous injection has been given. In emergency cases permission should be obtained from the supervisor before the sleeves are cut.

7. *Staining linen through the use of chemicals that are damaging to the fiber or impossible to remove.* To avoid this source of trouble, a bundle containing a set of old or previously stained linen should be kept on each ward or floor. When treatment is begun, the laundry should be notified and requested to continue the supply of such linen until notified to discontinue. The supervisor or nurse in charge should be responsible for keeping the initial set of stained linen on hand at all times.

8. *Staining linen by the use of nail polish or lipstick.* Rules informing patients to abstain from the use of cosmetics or toilet articles should be strictly enforced.

9. *Staining linen by the use of softened rubber draw sheets that adhere to bed linen.* These sheets should be replaced as soon as the nurse notices that the rubber surface has become softened. The resulting stains often cause unnecessary work in the laundry as they are difficult to remove.

Tears and Cigarette Burns

10. *Damaging linen by not removing pins or glassware when sending it to the laundry.* Ordinary care when changing beds should remove the possibility of damage from this cause.

11. *Damaging linen with cigarette burns.* Rules regarding smoking should be strictly enforced. Damage in dormitories may be frequent and the offenders should be made to pay for the loss.

12. *Losing linen through discard-*

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(above) This Nairn Linoleum floor,
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ing small articles like caps, masks or ice bag covers on the floor. From there they are frequently put into the waste basket and burned with waste. This can usually be traced to attendants and interns who leave the operating rooms without discarding caps and masks. Signs on operating room exit doors may help. The man who sweeps the laundry will bear watching since he will avoid bending to pick up anything.

13. *Losing various types of binders that the patients take home.* Request deposits whenever possible and there will be fewer losses.

14. *Damaging linen by pinning.* This is done by nurses who use bath towels and gowns for aprons. It is cheaper to allow them to wear aprons.

15. *Losing blankets and bath towels in the summer time.* If the hos-

pital is near the sea or a lake, blankets and towels add to a pleasant afternoon's outing of the employees. They will often leave them there. Strict enforcement of regulations alone will help.

16. *Losing kitchen and waiters' towels and aprons.* These will be found in the kitchen help's locker room. From there they may find their way to the incinerator or be used for rags to clean automobiles. Regulations covering this possible source of loss are the responsibility of the dietary department.

A great many abuses still remain to be added. These, however, are the most frequent.

Attention to the human factor, coupled with a system of linen control and cooperation between departments, is the answer to a more satisfactory linen inventory.

HOUSEKEEPER'S CORNER

• "A good housekeeper must be honest and fair-minded with her employer, her employees and guests," says Wilbur Emerson, president of the Croydon Hotel, in outlining the qualifications of a hotel housekeeper. Since many of these qualifications apply to the hospital housekeeper, we are going to list them for you.

"She must know the essentials of housekeeping; she must know quality in all sorts of materials and supplies; she must be an interior decorator, although not in the professional sense; she must be open minded, and she must keep in touch with the newest equipment and supplies as well as with trends in decoration. She must never lose sight of practical values; she must be able to smooth out difficulties both with the guests and the employees; she must know and understand people and must recognize individual whims of guests and be sympathetic to them. She must be able to choose employees wisely and get along well with them; she must be able to get them to give their best efforts and be loyal to the hotel.

"The most important asset for a successful housekeeper," Mr. Emerson declares, "is executive ability. If she cannot organize her department and the work that is to be covered and if she cannot train and direct the people under her, she will never be successful."

Mr. Emerson also warns that a housekeeper should be careful in selecting the man under whom she is to work, to be sure that he is someone with whom she can work.

• "Choosing a person for a given job should receive grave consideration," according to Althea C. Berry, executive housekeeper of the Albany Hospital, Albany, N. Y.

"It means a great deal to you and to the applicant to find the right person for the right place. There are a few rules that always hold good. A neat clean appearance, a direct manner of speech and an ability to look you squarely in the eye are what we all demand, but the ability really to judge a person is heaven sent and we all go far astray at times. A tryout often proves surprising, sometimes for the worse, sometimes for the better. As the pay roll of the housekeeping department in any large institution is second in size, a housekeeper has plenty of opportunity to perfect her skill and her woman's intuition when employing personnel."

These Qualities Bring Success

ADELE B. FREY

THE housekeeping department is the pulse of the institution; it has a close contact with the guest or patient. Work must be organized and well planned in order that perfect service can be given at 7 o'clock in the morning as well as at midnight. Remember, the individual does not care and is not interested in the handicaps under which the housekeeper may have to work; he wants "service" and that is what we must be prepared to give him.

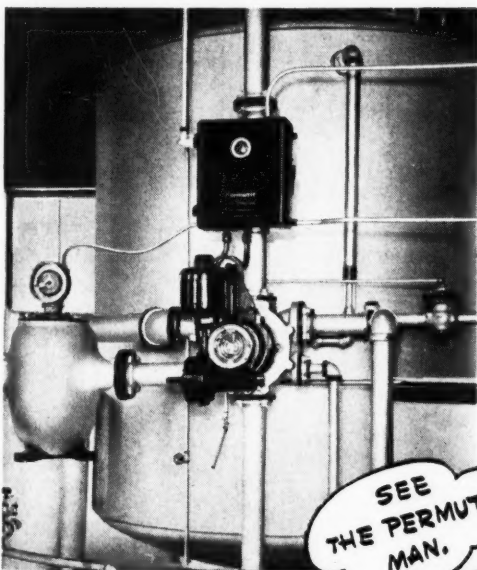
Below are a few rules and thoughts that may help housekeepers to become successful executives:

1. Be willing to start at the bottom.
2. Do not join the "wrecking crew"; be a member of the construction staff.
3. Learn to obey before you command. When you do command, do so with tact and diplomacy and never be domineering.
4. Try to sell yourself by strong ability.
5. Be honest with yourself as well as with others.

From an address by Miss Frey, executive housekeeper, Hollenden Hotel, Cleveland, at Cornell University.

6. Exercise self-control.
7. Be punctual.
8. Be brief and to the point in your statements.
9. Treat those in your charge as you wish to be treated by your superior.
10. Always be polite and courteous. These are qualities indispensable to an executive.
11. Adjust yourself and your time to your work; do not let outside interests take too much of your time.
12. Tackle your work with the same eagerness you tackle your sports and recreation. Pleasant duties will never become drudgery.
13. Remember that housekeeping requires long hard hours, but it is also most interesting work—never a dull moment, never two days that are alike.
14. Keep posted on current events in your profession by reading the leading professional and trade publications.
15. Join several organizations, clubs or groups that will be beneficial to your profession. Be a good member. Share your knowledge and experience with other housekeepers.

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AND SAVE MONEY
TOO!**



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Coffee Shop Is Popular

REEVA HINYAN



Left: A feature of the coffee shop is the magazine stand from which a bus boy carries newspapers and magazines to the patients each day. Below: The kitchen in which all of the short orders are prepared.



AFTER an exhaustive survey, the California Hospital, Los Angeles, reached the following conclusions with regard to a coffee shop:

1. Large hospitals strategically located should conduct a pay meal service department as a convenience to doctors, special nurses, employees and guests.

2. Such restaurant service should be under the supervision of a trained dietitian.

3. This service should be entirely under the supervision of the management of the hospital.

The coffee shop at California Hospital is an outgrowth of a soda fountain service on a lease basis, an arrangement that did not prove practical because it was necessary to use the hospital kitchen as well as other facilities of the hospital. Another difficulty lay in the need for flexibility to permit an exchange of employees.

Miss Hinyan is the dietitian at California Hospital, Los Angeles.

It was also found that the facilities of a soda fountain were too limited to meet all the needs in serving doctors, special nurses and visitors, as well as ambulatory dietetic patients, with adequate meals when such service was not available in the immediate environment of the hospital. Therefore, the soda fountain was taken over directly as a hospital department and the facilities were enlarged to include booth and table service with a seating capacity for 50 people. A short-order kitchen was also included.

At first, when the soda fountain was taken over from a lease arrange-

ment, the head soda fountain clerk was made manager. This did not result in satisfactory service or in recovering operating costs. Therefore, a trained dietitian was placed in charge as manager at a salary of \$100 per month. Her knowledge of food costs and her ability to analyze expenses enabled her to put the department on a paying basis with much improvement in service.

As it is now operated, the coffee shop has 10 stools at the soda fountain and 40 seats in booths. An adjoining room was remodeled to serve as a preparation kitchen containing an electric grill for broiling, electric toasters, waffle irons, a steam table, a cold table and ample refrigeration space.

The shop itself is well lighted and equipped with a soundproof acoustical ceiling. A two-way call system is used for transmitting orders to and from the preparation kitchen. Electricity is used for cooking to eliminate fumes and odors in the coffee shop. The preparation of such foods as soups, roasts and vegetables is done in the main kitchen; they are sent by a dumb-waiter to the steam tables in the coffee shop kitchen.

The china is sent to the main hospital for washing. Silver and glassware are washed in the service kitchen. A sterilizing rinse is used for all glassware and silver.

Racks and showcases display cigars, cigarettes, candy, magazines and all daily papers. The magazine list consists of 190 publications. Each morning and evening a bus boy carries newspapers and magazines to all patients' rooms.

Service is continuous from 7:00 a.m. to 11:30 p.m., with specified hours for each meal, when the cooked food is served. At all other hours, à la carte service is available. Special fountain and à la carte orders are sent to patients and visitors in rooms in the hospital.

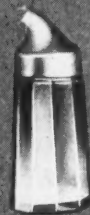
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The soda fountain is popular with patients, visitors and staff members.

diets to out-patients who eat regularly at the hospital on a diet prescribed after consultation with the doctor and dietitian. Most of such special diets are prepared in the main diet kitchen and are sent to the coffee shop where they are served in accordance with the directions of the dietitian.

The dietitian in charge of the coffee shop has a staff of one cashier, two cooks, one bus boy, five full-time waitresses and two part-time helpers. She trains her personnel to render prompt and efficient service, since many of the patrons are in a hurry.

No publicity has been given to the coffee shop, but patrons keep the place well filled and on most days an overflow for luncheon and dinner must be served in an adjacent dining room that is opened for their convenience. We feel that the wide variety of foods served at a moderate price and prepared under the most sanitary conditions, plus cheerful, light and attractive surroundings, are

the principal reasons for its popularity. Equipment consists of specially designed china, glassware and linens. The sandwiches are famous because the bread is generously buttered and filled. Coffee with cream is served for 5 cents and additional cups are given without extra charge. Special attention is given to salads and short orders.

The space occupied by the coffee shop could not well be used for any other purpose, since it is on the main floor on which there are no patient accommodations. It gives an added service to the doctors, special nurses and visitors who come to the hospital at all hours, as well as offering a means of serving special orders to patients and their guests at hours other than the regular serving time on the floors. The revenue derived from the shop is comparable to that derived from space rented to patients. This revenue goes into the regular operating account of the hospital and assists in carrying out free service.

COFFEE SHOP SALES

For year ending Oct. 31, 1938

Income—	
Fountain and Lunch.....	\$30,097.73
Less Cost of Merchandise Sold.....	15,676.04
Net.....	\$14,421.69
Cigars and Magazines.....	\$ 9,480.06
Less Cost of Merchandise Sold.....	7,489.18
Net.....	\$ 1,990.88
Income From Sales.....	\$16,412.57
Expense—	
Salaries.....	\$ 7,010.96
Replacements of China.....	579.00
Miscellaneous Supplies.....	288.99
Total.....	\$ 7,878.95
Income Before Deduction of Proportion of General Hospital Administration and Depreciation.....	\$ 8,533.62

Luncheon Suggestions

30 cents

Ham timbale with parsley sauce
Buttered fresh spinach
Pineapple Waldorf salad

or

Cold sliced roast beef, ham and
liverwurst with Swiss cheese
Potato chips and salad

Roll

Butter

Coffee, milk, buttermilk or coca cola

Dinner Suggestions

40 cents

Cream of asparagus soup

or

Tomato juice

Roast veal with dressing

or

Swiss steak with vegetables
Escalloped potatoes au gratin

Buttered green peas

Combination vegetable salad

Roll

Butter

Coffee, milk, buttermilk or coca cola

75 cents

Grapefruit and avocado cocktail

Vegetable soup

or

Tomato juice

Broiled tenderloin steak

or

2 Broiled lamb chops with sautéed
pineapple

French fried potatoes

Fresh asparagus or lima beans in cream

Stuffed tomato salad

Roll

Butter

Coffee, milk, buttermilk or coca cola

Choice of dessert

Club Breakfast

20 cents

Choice of orange juice, prunes or
applesauce

Toast and jelly

Coffee

30 cents

Orange juice, tomato juice or half
grapefruit

Hot cakes or waffle with butter and
syrup

or

Grilled ham, bacon or sausage with
one egg

Fried potatoes

Toast and jelly

Coffee, tea or milk

40 cents

Choice of any fruit or fruit juice in
season

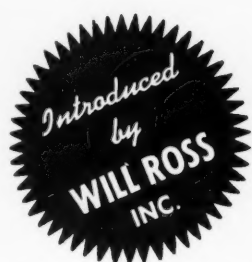
Hot or cold cereal with cream

Broiled ham, bacon or sausage with

2 eggs and fried potatoes

Toast and jelly

Coffee, tea, milk or buttermilk



HOSPITALS

have always Needed this

KENWOOD *Hydraulic* BED-END ELEVATOR!

Raising the end of a bed has always been a strenuous task, requiring extra help and disturbing the patient.

But now, with the Kenwood Hydraulic Bed-End Elevator, even the slightest nurse can quickly and easily elevate either end of the bed to any desired height. Hydraulic power does the heavy lifting. And with the Elevator in position, the bed can be wheeled wherever wanted without disturbing the patient. It is fast, sure, foolproof • This is one of many Will Ross contributions to improved and simplified Hospital Technique.

For slightly more than twenty-five years Will Ross, Inc., has been deeply concerned about ways and means of making hospital practice simpler and more efficient. We have tried to crystallize this concern in some tangible form, wherever possible. We have listened earnestly to much "wishful thinking", many "hunches" and countless suggestions from people who run hospitals or work in them. Out of this have come ideas that have frequently developed into simplified or improved hospital technique . . . of which the Kenwood Hydraulic Bed-End Elevator is an example.

We shall be glad to give you complete information.



WILL ROSS, INCORPORATED

*Wholesale Distributors and Manufacturers
of Hospital Supplies*

3100 WEST CENTER ST.

MILWAUKEE, WISCONSIN

Food Clinic Reaches Public

MABEL W. PERRY

THE usual interpretation of the functions of a food clinic as outlined by the American Dietetic Association indicates a belief that such a clinic is essentially therapeutic. In fact, in many institutions the food clinic is an outgrowth of a specialized clinic, such as the diabetic clinic. There is a logical explanation for this development based on the differences between hospital and ambulatory patients.

The hospital patient has no responsibility for his own care, that is, the physician orders the treatment and the nurse, technician and dietitian execute these orders. In the case of the hospitalized diabetic patient, the doctor orders the food prescription, the dietitian transposes the order into foods, which are then prepared under her supervision, and at the appointed time the nurse carries the food tray to the patient. The responsibility is not the patient's; all he has to do is to eat the food prepared for him. If he does not do this, the dietitian recalculates the food prescription and makes up the differences by adding to his diet concentrated sources of the food constituents that were found to be low. In this way the diet order is kept constant.

Patient His Own Doctor

The ambulatory patient, however, visits the out-patient department to see the physician who outlines the treatment but he must carry it out by himself. He becomes his own nurse, technician and dietitian and at the same time carries on his normal life as a part of the household and the community. The ambulatory patient, therefore, must fully understand his condition and must be carefully instructed so that he can carry out the physician's orders.

The success of the food treatment of the ambulatory diabetic patient depends not only upon the patient's understanding of diabetes and the relation of diet to this condition but also upon the economic status of his family. The patient must know, first, what he can eat and, second, how to

select his diet from the foods that are prepared for the family. If this family happens to be of a nationality other than American the problem becomes even more complex.

The out-patient physician soon saw the importance of individualized and detailed instructions for diabetic patients. Thus, the services of a dietitian became a part of the routine setup of the diabetic clinic.

With the increasing use of diet as a part of medical care, the physician realized that the instructions given by the out-patient dietitian could save him much valuable time with cases other than diabetic and that these instructions would produce the results desired by the dietary treatment without making it necessary for the patient to change his mode of living or to increase his food budget to any marked degree. From this point the growth of the nonspecialized food clinic has been amazingly rapid. Today there are 31 food clinics in the United States with at least one full-time dietitian in each.

Many of the patients who need therapeutic diets as a part of their medical care are accustomed to daily food intakes that are inadequate in one or all of the food constituents. Therefore, the function of the food clinic is to assist not only those patients referred to it for any type of therapeutic diets but also those who need dietary regulations because of faulty food habits that may result from lack of knowledge or lack of income.

"New Technical Efforts Toward a Better Nutrition," issued by the League of Nations, states, "In spite of the application of existing knowledge of medicine and hygiene, the physical condition of a large portion of the human race is still far below accepted standards; and recent investigations have established the fact that the inferiority is largely due to imperfect feeding." It follows that widespread public instruction about food values is imperative.

The food clinic now has a challenging opportunity to serve as a

teaching center for normal nutrition. The ambulatory patients it reaches, those seeking to regain lost health, are most receptive to information aimed at maintaining optimum health for their families. Hence, the original therapeutic phase has become only a part of the function of an efficient and progressive unit as the food clinic keeps pace with the trend toward preventive medicine.

Posters Stress Diet Rules

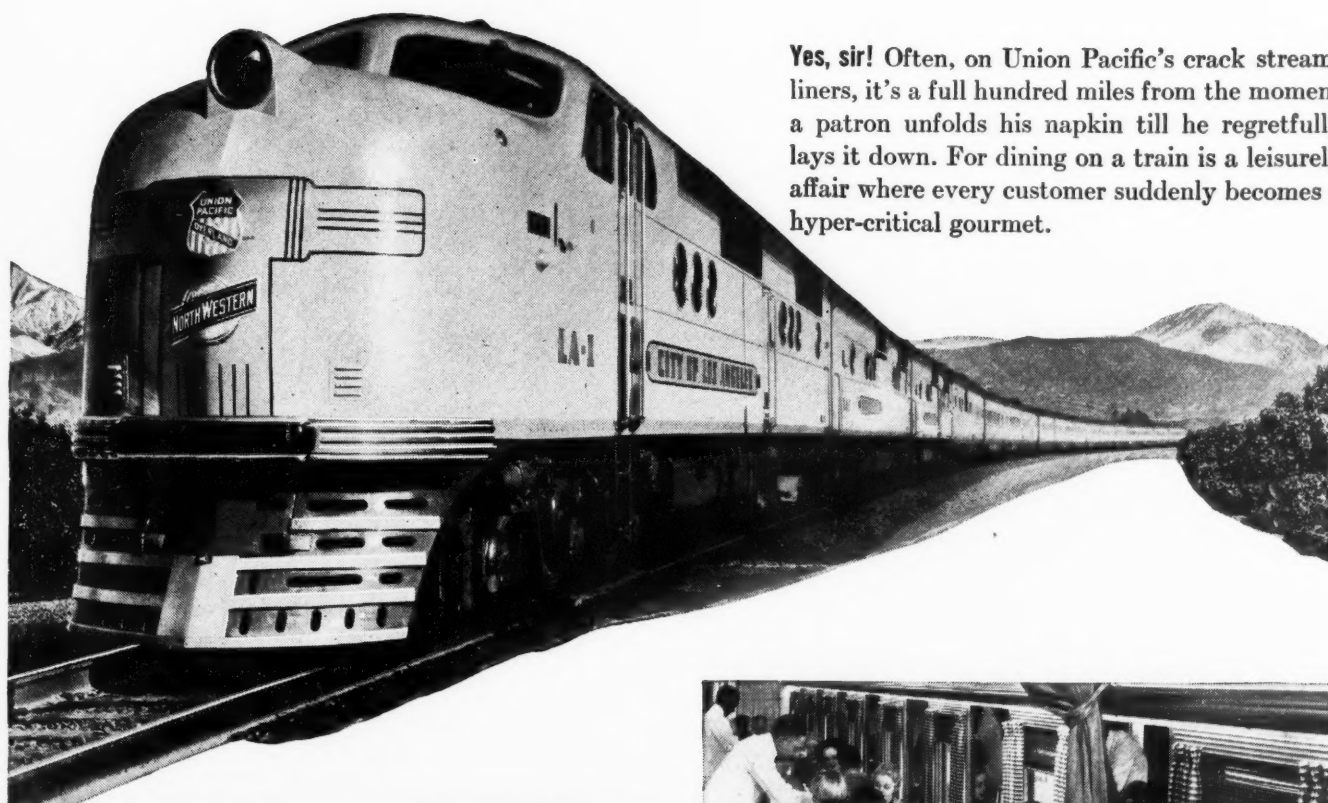
In the waiting room and offices of the nutrition clinic of the New York Hospital, New York City, are posters and simple exhibits stressing the essentials of the "protective diet" with emphasis on the comparative costs of the sources of the food constituents. This emphasis on the essentials for a well-balanced diet is made again during the patient's interview with the dietitian. He is taught the needs of the body in terms of the food constituents and is instructed as to their various sources within the limits of his own diet.

It is frequently necessary for the dietitian in the clinic to work out a food budget for the entire family to assure the diet ordered for one member. There is quite a difference between "low cost food suggestions" and specific budgeting advice. The former has little value in the typical nutrition clinic case. The few pennies saved are soon spent elsewhere and long lasting changes in the food purchases of the family are rarely obtained. However, with the patient and the dietitian working together on the family's food purchases at weekly intervals, there is a possibility for improvement in the dietetic value of the diet.

Aside from individual instruction, the nutrition clinic conducts nutrition education classes in the various clinics of the out-patient department. This program was initiated in order that patients whose conditions do not indicate a need for specific treatment by diet may acquire a scientific knowledge of the relation of general food and health habits to the body.

Miss Perry is dietitian in the nutrition clinic, Department of Nutrition, New York Hospital, New York City.

What you can learn from a meal 100 miles long...



Yes, sir! Often, on Union Pacific's crack streamliners, it's a full hundred miles from the moment a patron unfolds his napkin till he regretfully lays it down. For dining on a train is a leisurely affair where every customer suddenly becomes a hyper-critical gourmet.



There's not too much room, either, for a chef's best efforts. Look at this gleaming kitchen. It's complete from A to Z, yet only 24 by 7 feet. No wonder that Union Pacific uses such a large quantity of Birds Eye Frosted Foods . . . for they combine both uniformly high quality and unmatched simplicity of storage, preservation, and handling.



Out where tasteful surroundings, snowy linen, and shining silver whet already keen appetites, come perfect, delicious meals. And Mr. E. C. Webster, Manager of Union Pacific's Dining Car and Hotel Department, praises Birds Eye's contribution: "We consider Birds Eye Frosted Foods valuable in maintaining our strict standards. Their utter freshness, full, delicate flavor, and complete variety regardless of season enable us to serve world-famous meals."

In season and out—over 2 dozen kinds for menu variety

Asparagus Tips—
Select, Medium,
Jumbo
Asparagus Cuts
Broccoli
Brussels Sprouts

Green Beans—
1 1/2" cut and
French Style
Wax Beans
Lima Beans—
Baby Green and
Garden Run

Cauliflower
Corn on Cob
Cut Corn—
Golden Bantam and
Country Gentleman
Squash

Spinach
Green Peas
Peaches
Blueberries
Raspberries
Rhubarb
Strawberries

BIRDS EYE
FROSTED FOODS

FROSTED FOODS SALES CORP.
250 Park Avenue, New York City



The cheerful, attractively furnished office of the chief dietitian.

In the obstetrical clinic, discussions are held three times a week in the open clinic while the women are waiting in turn to see the physician. Through short illustrated talks the fundamental health principles are visualized and reemphasized. It is not possible for the dietitian to spend the entire morning in the obstetrical clinic so, in order to assure some normal nutrition information for all of the pregnant women, a simple exhibit illustrating the points covered in the discussion is placed in the public health nurse's office through which the women must pass on every clinic visit.

Classes in normal nutrition, as well as in food budgeting or food values in relation to cost, are an outgrowth of the work in the obstetrical clinic. These classes are attended by women selected by social service workers or public health nurses as those most in need of detailed instruction.

In spite of the number of persons given individual diet instruction for a specific disorder or those who are made aware of the importance of the "protective diet" by nutrition education classes or merely by the posters, it is obvious that the majority of patients who come into the outpatient department do not have contact with the nutrition clinic. However, they are seen by at least one of the other allied medical workers (nurses, physicians, medical students or the social workers). Not infrequently the discussion of the patient's problems turns to a discussion of

foods and, unfortunately, the questions asked often go unanswered because of the worker's lack of accurate and practical information. Here again is an opportunity to spread correct nutrition facts to more people by educating these workers in the practical aspects of food and the components of the scientific normal diet.

Each student nurse spends two weeks in the nutrition clinic during her third year in training. She comes with an excellent background in nutrition theory and has done some practical work with therapeutic diets on the pavilions of the hospital. In the nutrition clinic are reviewed the fundamentals of normal nutrition and the changes necessary when the diet becomes therapeutic. The student sees the importance of adapting the diet to the individual, becomes familiar with the foods of the foreign-born and has an opportunity to work on budgets. She actually works with patients and by teaching them learns the technic of approach necessary for the success of the dietary instruction.

A simple nutrition education project, generally a small exhibit or a poster, is required of each student. This project makes clear to her the difference between specific and non-specific instruction. The two weeks of service in the nutrition clinic coordinates all the student nurse's nutrition work and makes her acutely aware of food as an integral part of the social life of each patient. Later, when she does her public health

nursing and enters the homes of patients she can make constructive suggestions for improving the family's food.

The medical student requires a different type of instruction. His excellent background in physiology and biochemistry provides a good theoretical foundation in dietetic principles, but he has difficulty with the actual construction of the diet and its transition to household measures. Besides this weakness in the mechanics of dietetics, the student forgets that his patient cannot and will not take orders regarding his food in the same way he will follow directions for medicine.

Six one-hour lectures are given at the beginning of each quarter to the group of students then entering outpatient service. During the quarter, the students in groups of two spend three mornings (a total of nine hours) in the nutrition clinic where, under the supervision of the dietitian, they give diet instructions to patients. At the end of this clinic clerkship, the medical student can construct a normal or therapeutic diet, adapted to an individual in terms of body needs, teach this diet in household measures and also recognize and appreciate still other factors to which the diet plan must be adjusted for successful outcome.

To aid the social worker in her analysis of the adequacy of a patient's total budget, the nutrition clinic supplies her with current food prices and a copy of a leaflet entitled "The Adequate Diet at Minimum Cost," adapted by the food clinic of the Boston Dispensary from the U. S. Department of Agriculture circular 296. The food prices plus the information contained in the leaflet make it possible for the social worker to compute quickly the cost of adequate food for a given family and to make out a weekly market order that will supply this food at the calculated cost.

Thus, with the aid of nurses, medical students and social workers, the food clinic is establishing itself as a factor in preventive medicine as it contributes to the general public education by reaching "those who fail to purchase good health because they do not know what to buy." With its flexible organization and practical type of instruction, it plays its part in bettering public health.

TOAST TREATS

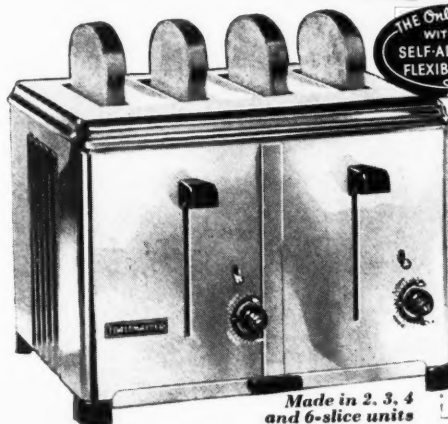


FOR THE

HOSPITAL DIET

TOAST IN THE HOSPITAL DIET

Toast is an attractive and easily digestible form of carbohydrate—ideal for BLAND DIETS, SURGERY DIETS, SMOOTH DIETS, LOW RESIDUE DIETS and for INFANT FEEDING as a supplementary food.



Made in 2, 3, 4
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THE ONLY TOASTER
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YOU will want a free copy of this interesting new booklet that contains so many illustrations of attractive tray set-ups for every meal in the hospital day . . . and is so full of appetizing suggestions for toast dishes and sandwiches of every type.

The material has been compiled in collaboration with several leading hospital dietitians—you will find it practical and stimulating in your difficult task of planning menus to brighten dull appetites and build good will for your hospital. The edition is limited, so we suggest that you send for your free copy today.

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Toronto

MAY WE SEND
YOU THIS
NEW BOOK

... to help you
in planning
your menus?

Creamed Meat in Butterfly Shells



Creamed meat made from the last bits of yesterday's roast and served in butterfly pastry shells makes a delightful service. The butterfly shells are made by dipping hot irons in batter and frying in deep fat. Creamed meat also may be served in patty shells.—INEZ S. WILLSON, *National Livestock and Meat Board, Chicago.*

RECIPES BY REQUEST

Southern Dinner (Fifty Servings)

- 12 cups rice, uncooked
- 8 bunches celery, chopped
- 8 pounds onions, chopped
- 8 cups fat
- 24 pounds pork shoulder, diced
- 8 pounds mushrooms
- 4 pounds lima beans (dry)
- 8 quarts tomatoes
- ½ cup salt

Clean and cut up celery stalks and leaves. Fry celery until transparent in half the fat in a kettle tightly covered. Brown pork cut into small pieces in remaining fat. Cover and cook slowly for thirty minutes. Wash and cook rice. Drain rice and combine with other ingredients. Bake in moderate oven until hot.

Tuna Fish Chow Mein (Fifty Servings)

- 9 cans tuna fish (12 oz.)
- 5 large onions, sliced
- 3½ quarts celery, chopped
- 3 pounds mushrooms
- ½ No. 10 can bean sprouts
- 1 cup flour

- 4 quarts gravy stock
- 1 bottle Soy sauce

Thicken gravy stock with flour. Brown mushrooms. Cook celery and then combine onions, celery, mushrooms, Soy sauce and bean sprouts with gravy stock. Add tuna fish just before serving. Serve on Chinese noodles or shoestring potatoes.

Orange Squares (Fifty Servings)

- 9 egg yolks
- 3 cups sugar
- 1 cup orange juice
- 2¾ cups flour
- 3 teaspoons baking powder
- 9 egg whites
- 9 teaspoons salt

Beat egg yolks until thick and lemon colored. Add sugar gradually and then orange juice. Combine dry ingredients and add to first mixture. Fold in beaten egg whites. Bake in large pans in moderate oven. Frost with following icing:

- Powdered sugar
- Butter
- Orange juice; Grated rind

FOOD FOR THOUGHT

• The results of an English study of the calcium requirement of the adult indicate that calcium and phosphorus equilibrium may be attained with 0.520 gm. calcium and 1.200 gm. phosphorus per day.

"These figures," according to the National Dairy Council, "represent the lowest level for maintenance and allow no margin against unforeseen loss, as is evidenced by the fact that subjects who were apparently in equilibrium on the lower intake went into marked positive balance when the intake was increased. H. C. Sherman in his 'Chemistry of Food and Nutrition' recommends that the standard for maintenance be set 50 per cent above the indicated average minimum, which would bring these figures to 0.78 gm. calcium and 1.80 gms. phosphorus. He adds, however, that 'it is doubtless better for family food supplies to furnish 1 gm. of calcium per capita per day.'

"The English investigators conclude that the calcium requirements of older men are much the same as those of younger adults. The effect, therefore, of long subjection to a diet low in calcium is not offset by increasing age. The body of the older man also resembles that of the young adult in that it readily retains calcium and phosphorus after depletion of these minerals."

• Are you looking for new suggestions to tempt the appetite? Turn to "Menu Making for Professionals in Quantity Cookery" by J. O. Dahl. After one look you will probably keep it within reach at all times. It includes many charts, such as quantities to purchase for 50 and 100, foods and their season, holiday schedules and standard weights and measures for portions. It may be purchased for \$3 from The Dahls, Haviland Road, Stamford, Conn.

Incidentally, the Dahls have another book full of menu suggestions. It is "Ideas From 1000 Menus" by Pat Pompilio. It promises to bring a sigh of relief from the perplexed dietitian. The cost is only 50 cents.

• Included on the bookshelf of every food worker should be "Adequate Family Food Allowances and How to Calculate Them." This is a new 36 page pamphlet sponsored by the Family Welfare Association of America, 130 East Twenty-Second Street, New York City, prepared by a committee from the social welfare and public health department, the American Home Economics Association and the American Dietetic Association. It is available for 40 cents.



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In A
Specialist"*



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373 West Ontario St., Chicago, Ill.
Please send free trial package and full details.

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Hospital _____
Address _____
City _____ State _____

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America's Leading Hospital **COFFEE**

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373 West Ontario Street Chicago, Illinois
Member of the New York Sugar and Coffee Exchange

October Menus for the Small Hospital

BREAKFAST

LUNCHEON OR SUPPER

Day	Fruit	Main Dish	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Orange Juice	Creamed Eggs on Toast	Cheese Fondue	Escalloped Potatoes	Tomato and Cucumber Salad, French Dressing	Orange Gelatin, Whipped Cream
2.	Baked Apple	Broiled Fish Roe	Spanish Omelet	Buttered Wild Rice	Waldorf Salad	Lemon Cream Cake
3.	Sliced Bananas	Soft Cooked Eggs, Muffins	Creamed Asparagus on Toast	Baked Potatoes	Spiced Pear and Cottage Cheese Salad	Jelly Roll
4.	Pineapple Juice	Bacon, Hot Rolls, Preserves	Meat Balls	Buttered Noodles	Baked Squash	Apple Pie, Cheese
5.	Tomato Juice	Sausage, Toast	Boiled Sweet Potatoes With Bacon	Cauliflower	Fruit Salad	Baked Custard
6.	Prunes	Poached Eggs, Honey	Panned Oysters on Toast	Mashed Potatoes	Lime Gelatin and Carrot Salad	Snow Pudding
7.	Grapefruit	Fried Apples and Bacon	Pork and Beans	Brown Bread	Cabbage Salad	Apple Betty
8.	Half Orange	Jelly Omelet, Popovers	Cold Meat Platter	Potato Salad	Tomato Stuffed With Cottage Cheese	Peaches and Cake
9.	Stewed Apricots	Toasted Raisin Bread, Boiled Eggs	Rice Croquettes, Cheese Sauce	Frosted String Beans	Mixed Fruit Salad	Hermits
10.	Canned Strawberries	Frizzled Dried Beef, Toast	Vegetable Plate: Candied Sweets, Cauliflower, Broiled Tomatoes, Buttered Carrots		Pear and Cream Cheese Salad	Macarons
11.	Applesauce	French Toast With Syrup	Baked Spaghetti and Cheese	Fried Egg Plant	Apple, Celery and Date Salad	Cream Puffs
12.	Prune Juice	Codfish Cakes, Muffins	Chicken à la King With Biscuits		Asparagus-Tomato Aspic Salad With Vegetable	Gingerbread, Whipped Cream
13.	Grapefruit Juice	Scrambled Eggs, Hot Biscuits	Baked Noodle Nest With Crabmeat		Buttered Frosted Peas	Fruit Cup
14.	Tomato Juice	Poached Egg on English Muffin	Creamed Chip Beef	Baked Potatoes	Grape and Orange Gelatin Salad	Spanish Cream
15.	Stewed Pears	Creamed Liver, Cinnamon Rolls	Cheese Soufflé	Broiled Tomatoes	Celery, Olives, Pickled Peaches	Rice-Raisin Pudding
16.	Melon	Canadian Bacon, Parker House Rolls	Baked Eggs With Tomato Sauce		Jellied Pimiento Salad	Pineapple Cake
17.	Sliced Bananas	Kidney Hash on Toast	Welsh Rabbit on Crackers	Potato Chips	Mixed Fruit Salad	Coconut Cookies
18.	Half Orange	Wheat Cakes, Syrup	Corned Beef Hash	Hot Slaw	Grilled Tomatoes	Lime Ice
19.	Frosted Raspberries	Coddled Eggs, Muffins	Broiled Meat Cakes	Buttered Potatoes	Green Beans	Norwegian Prune Pudding
20.	Applesauce	Fried Corn Meal Mush, Syrup	Broiled Mackerel	Escalloped Potatoes	Buttered Beets	Lemon Snow, Custard Sauce
21.	Figs	Scrambled Eggs, Hot Biscuits	Tomato Filled With Corn Creole Gratin	Creamed Celery and Carrots	Fruit Salad	Orange Cornstarch Pudding
22.	Orange Juice	Bacon, Coffee Cake	Creamed Cod Fish	Baked Potatoes	Lettuce With Russian Dressing	Gingerbread With Whipped Cream
23.	Grapefruit	Soft Cooked Eggs, Muffins	Hamburg Steak	Creamed Potatoes	Frosted Peas	Caramel Date Blancmange
24.	Tomato Juice	Ham and Eggs, Toast	Chicken Giblets With Rice	Buttered Carrots	Cabbage and Pineapple Salad	Lemon Cream Pie
25.	Prune Juice	Codfish Cakes, Toast	Fried Ham and Eggs	Baked Potatoes	Frosted Spinach	Canned Pears, Cookies
26.	Stewed Apricots	Sausage, Muffins	Spanish Pie	Sweet Corn	Pear and Cream Cheese Salad	Poor Man's Cake
27.	Baked Apple	Scrambled Eggs, Toasted English Muffins	Salmon Patties With Lemon	Escalloped Potatoes	Sliced Tomato Salad, French Dressing	Apricot Whip, Whipped Cream
28.	Pineapple Juice	Coddled Eggs, Hot Biscuits	Liver and Bacon	Hashed Brown Potatoes	Spiced Pear and Jelly Salad	Steamed Carrot Pudding, Hard Sauce
29.	Orange Juice	Wheat Cakes, Bacon Curls, Syrup	Hamburgers and Buns	German Potato Salad	Sliced Tomatoes	Glazed Apple
30.	Melon	Scrambled Eggs, Bran Muffins	Jellied Meat Loaf	Potato Cakes	Celery Cabbage Salad	Marble Cake
31.	Dried Fruit Compote	Soft Cooked Eggs, Toast	Celery and Tuna Soufflé	Buttered Potatoes	Waldorf Salad	Ginger Snaps and Cider

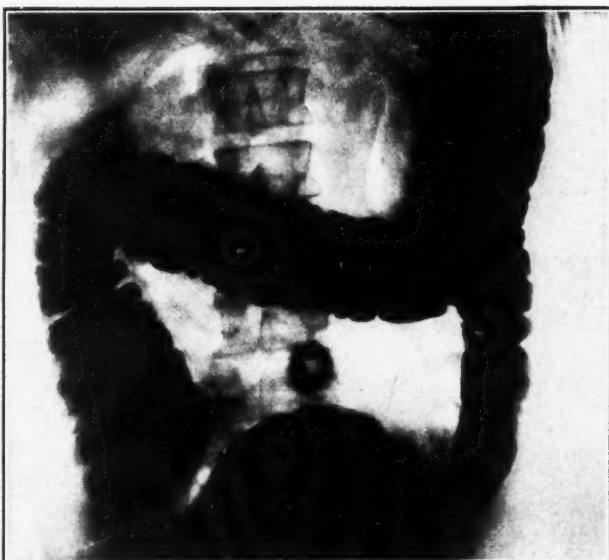
Recipes will be supplied on request by The MODERN HOSPITAL, Chicago. Space precludes listing of cereals, several varieties of which are always offered for breakfast.



Here's One Reason



Atonic colon, condition often due to diet of soft foods and insufficient bulk.



Normal colon—indicating that needed bulk has been included in diet.

**Why RY-KRISP is helpful
as a natural corrective in
cases of common constipation**

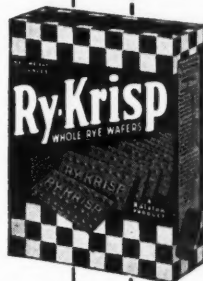
As you know, many cases of common constipation are caused by insufficient bulk. Eating Ry-Krisp regularly as bread has proved helpful in cases of this kind because its high bran, high pentosan and crude fibre content encourage normal bowel action.

Because most people dislike the thought of any unpleasant dosage, your patients will welcome the natural Ry-Krisp way which aids in correcting common constipation. Made of choice whole rye, salt and water—and baked by a unique crisping process which brings out the appetizing rye flavor—Ry-Krisp has a satisfying goodness enjoyed by young and old.

For free samples and the Research Laboratory Report on Ry-Krisp, use the coupon below.

RY-KRISP

Whole Rye Wafers



RALSTON PURINA COMPANY
Dept. MH, 3106 Checkerboard Square, St. Louis, Mo.

Please send me **FREE** samples of Ry-Krisp, and
a copy of your Research Laboratory Report.

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(This offer limited to residents of the U. S. and Canada.)

Hospital Pharmacy

Medicinal Incompatibilities

JAMES B. BERARDI, M.D.



Before any medicinal preparation is administered to a patient the formula should be carefully checked to guard against incompatibilities. Photograph from Abington Hospital, Abington, Pa.

Therapeutic incompatibility depends on the question of pharmacologic antagonism between two or more substances, *i.e.* between substances that act diametrically opposite to each other on the living organism. At times it is desirable to combine two or more substances so as to produce a corrective action and, in such cases, this combination cannot be classified as a therapeutic incompatibility.

The question of incompatibility is becoming more and more apparent because physicians are prescribing proprietary medicines in combination with standard or other proprietary preparations. The physician often does not know the complete formula of these preparations. Incompatibilities may involve all three of the classes mentioned or a combination of any two or of a single class. In prescriptions, the physician is entirely responsible for incompatibilities provided the pharmacist uses the proper art in compounding and dispensing the prescription. Therefore, it is important that the physician possess a thorough knowledge of the solubilities and physical properties of the various substances he desires to prescribe as well as the chemistry and therapeutics of these substances.

Before the physician attempts to write a prescription, he must decide what form of the finished product he desires; that is, a mixture, a solution, a powder, a capsule or a tablet. He must then consider what other substances, if required, can be combined in order to obtain a compatible and palatable preparation. If a mixture or liquid is to be prescribed, a suitable vehicle must be selected. If a capsule is to be prescribed, the powder or powders must be stable and not liquefy when combined. The question of therapeutic incompatibility lies within the hands of the physician alone.

INCOMPATIBILITY is best defined as the lack of agreement of various substances or the quality of not being miscible, combined or soluble or of being physiologically or therapeutically antagonistic. Incompatibilities may be divided into three classes: physical (or pharmaceutical), chemical and therapeutic.

Physical or pharmaceutical incompatibility depends on relative solubility. Deliquescent substances that, when put up in the form of a powder, capsule or pill, have a tendency to melt or become liquid by the absorption of water from the air are considered pharmaceutical incompatibilities. At times it is desired that an insoluble powder be suspended in a vehicle so that the

resulting mixture can readily be shaken up and approximately uniform dosage obtained. This in the strict sense is not an incompatibility. The same is essentially true in a mixture containing immiscible liquids. The latter statement is more or less of a paradox, for if one desires such a mixture he cannot be accused of his lack of knowledge.

Chemical incompatibility results when new substances are formed that are less soluble and, therefore, precipitate out of solution, or are more readily soluble or result in a poisonous substance. At times chemical reaction may take place with the formation of a new substance and the evolution of a gas. These phenomena may be desired, in which case there is no incompatibility. If these reactions are not desired and if the resulting change renders the preparation less active or destroys all activity from a therapeutic standpoint, incompatibility takes place.

Doctor Berardi is the pharmacist at the Veterans Administration Facility, Dwight, Ill. This paper is published with the permission of the medical director of the Veterans Administration who assumes no responsibility for the opinions expressed or the conclusions drawn by the author.

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NEW YORK



In prescribing a tincture, fluid-extract or a substance of high alcoholic content to be carried in a vehicle, such as an elixir, the physician can pass the responsibility on to the pharmacist by prescribing an iso-alcoholic elixir as a vehicle. The pharmacist must then determine the alcoholic strength of the elixir so that it will be of the same strength as the active preparation; otherwise, the active constituents of the tincture or fluidextract will be thrown out of solution.

A few examples of the various types of true physical incompatibilities and of apparent (but not real) incompatibilities are as follows: A solution of gummy substance, such as tincture of myrrh, will become turbid and precipitate on addition of a strong alcoholic solution because this gum does not dissolve in a strong alcoholic menstruum. Likewise, a solution of resinous substance, like tincture of ginger, will become turbid on addition of water because the resin, while soluble in alcohol, is not soluble in dilute alcohol. A powder, such as boric acid, when prescribed in a supersaturated solution is incompatible because the excess boric acid will crystallize out and, if this supersaturated solution containing the crystals is used as an eye-wash, the fine crystals might irritate the eyes. Milk of magnesia contains an insoluble substance suspended in water but, since it readily can be shaken up to form a magma, is not considered an incompatible preparation.

As an example of chemical incompatibility one may note that a solution of silver nitrate combined with adrenalin chloride results in a precipitation of silver chloride which is inactive. Elixir phenobarbital combined with sodium salicylate results in a precipitation of phenyl salicylate which is inactive and thus the sedative action of the phenobarbital is destroyed. Amidopyrine, which is sparingly soluble in water, becomes readily soluble if sodium salicylate is added. A chemical reaction takes place but this is desired because a clear solution results and thus this is not an incompatibility. Likewise, when mercuric chloride and potassium iodide are combined in solution, the change that occurs is desirable; potassic-mercuric iodide is formed and improves the product.

Therapeutic incompatibility may be illustrated by a prescription containing atropine and pilocarpine which are incompatible because the former is a mydriatic while the latter is a miotic. In other words, they are antagonistic in that one dilates the pupil of the eye while the other contracts the pupil. They possess other systemic antagonisms. Pepsin is incompatible in an alkaline medium because the action of the pepsin is destroyed. Likewise pancreatin is incompatible in an acid medium be-

cause the action of the pancreatin is destroyed. If belladonna is prescribed with a laxative, this is not considered an incompatibility, because the belladonna is added as a corrective to lessen the griping of the laxative and thus increase the efficiency of the purgation. It is true that the belladonna tends to lessen peristalsis, but in doing this it prevents to a large extent too strong a constricting effect of the laxative on the bowel, which would delay the passage of feces through the bowel.

Night Watch on the Pharmacy

HARVEY A. BOESE

THERE are various means of safeguarding the contents of the pharmacy at night. The pharmacy is usually located on the first floor near the front entrance or near the night clerk's office. In many hospitals, an hourly check of the pharmacy can be made by the clerk or watchman on duty to ascertain whether anyone has entered or tampered with any of the entrances or windows.

A good plan for a pharmacy that has a compounding and dispensing room is to have one entrance that is kept locked at all times during the day and night. One or two dispensing windows should be sufficient to care for the customers. The compounding room should contain a large well-ventilated closet or cabinet that is accessible only through the room. Nonpoisonous drugs may be kept in the main part of the compounding room and narcotics and alcoholic preparations should be stored in a safe or in a strong box in the closet. It is suggested that special locks be used throughout.

The windows to the compounding room may be barred if the pharmacy is on the ground floor and within easy reach of the ground. Even if the windows are not barred, some means of locking them should be installed. All biologicals and perishable drugs may be locked in the refrigerator which practically all pharmacists have for that purpose.

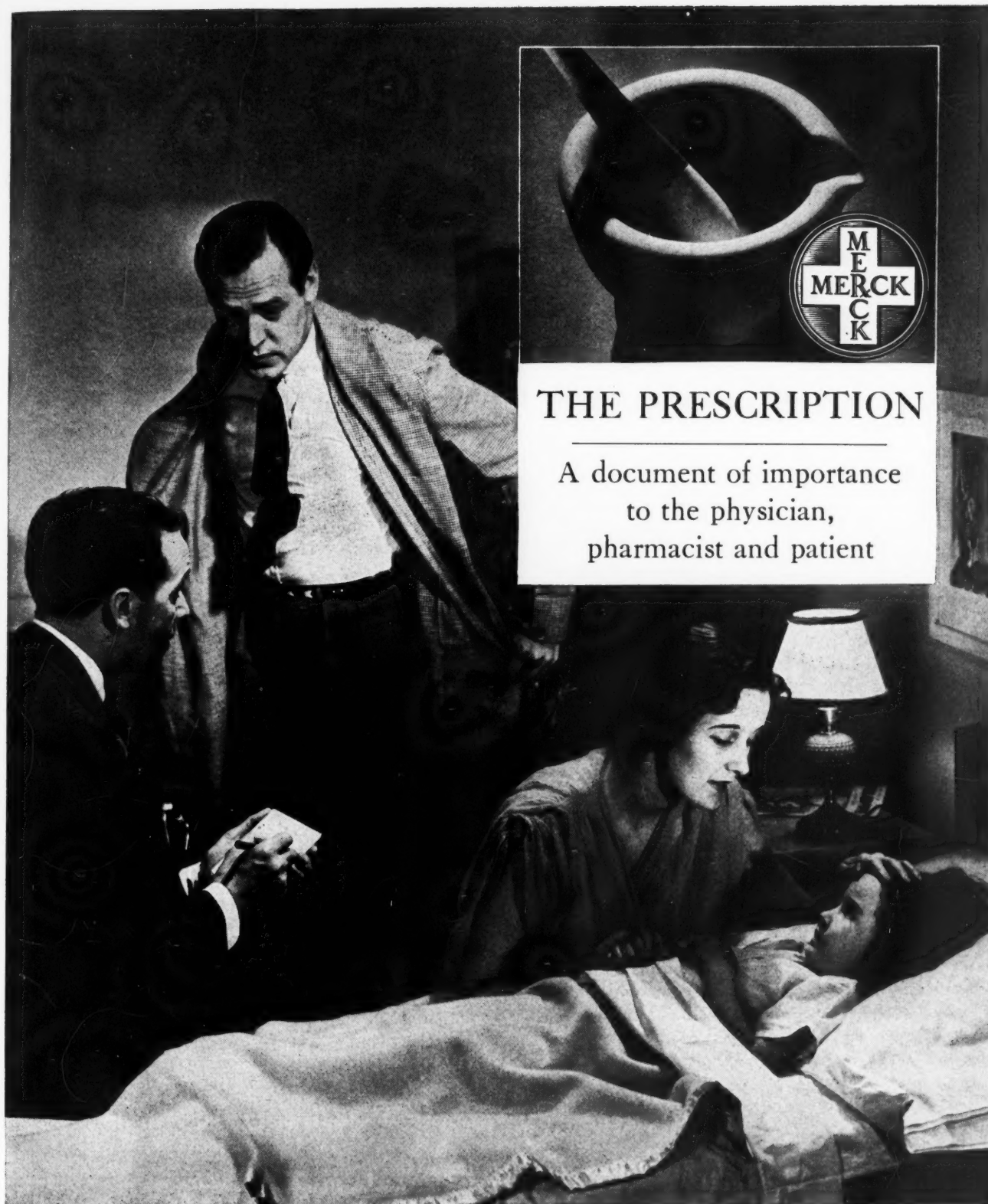
The next step is to make sure that the persons working in charge of

the pharmacy are absolutely trustworthy. The pharmacist in charge should be responsible for the proper locking of all the departments of the pharmacy and should be the only person to have access to the keys or combinations used. A reliable man may assist him as relief pharmacist. In this way, someone will be on call at all times in the event that an emergency arises and drugs are needed immediately. The chief pharmacist and his assistant should be the only persons permitted to handle alcoholics or narcotics.

Another aspect of protection relates to the maintenance of proper temperature and humidity. At night when all the windows and doors are closed, there is a tendency for the temperature to rise and the air to become dry. A thermostat ventilating system with a humidity control should be installed and the temperature kept as near body temperature as possible, not only for the protection of the drugs but for the health of those who will work there in the daytime. Good ventilation will prevent a hot stuffy atmosphere that is tiring to those who have to work in it. Medicinal substances are best preserved when temperature and humidity are both maintained at an even level.

Many hospitals arrange their work in such a manner that all of the needs of the various wards and clinics are taken care of during the daytime, so that it is seldom necessary for the pharmacist to enter the pharmacy at night to obtain drugs for these departments.

Sergeant Boese is pharmacist at the U. S. Penitentiary Hospital, Leavenworth, Kan.



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Program for Pharmacy Interns

FRANK L. VARGA

THE training of a hospital pharmacy intern, if it is to be of material aid to the intern as well as to the hospital pharmacist, is important; serious consideration must be given it. It should be planned in such a manner that the intern will derive all the benefits of a varied and instructive program. Nothing should be taken for granted; simply because the intern was supposed to have acquired certain knowledge through his scholastic training is no reason to expect him to be as efficient and observing as the pharmacist who has had years of experience.

First, the intern must be familiarized with the various departments of the hospital. The pharmacist should explain how these departments aid him and what he, in turn, does for them. After this explanation, with the full comprehension on the part of the intern of the hospital's daily routine and his part in that routine, he should be ready to participate actively.

The intern begins by helping the pharmacist fill trays from the hospital departments. The formulas and preparations of the simple solutions, such as green soap, alcohol and mouth washes, are explained and the preparations are supervised by the pharmacist. After he learns how to prepare these simple solutions, this becomes one of the intern's daily duties.

The next step is to permit him to fill the containers from the trays with ready-made tablets, capsules and solutions. Along with this, he may be permitted to aid in the preparation of capsules and of such solutions as iodine, mercurochrome and other every day necessities.

During the routine work of filling the morning trays, it is advisable to explain the various drugs and biologics that are uncommon to the average student. Many ampoules and

The author is the pharmacist at the Easton Hospital, Easton, Pa.

During his apprenticeship the pharmacy intern benefits from the knowledge and experience of the senior pharmacist, the author states. Later, when the intern has completed his training, he, in turn, will impart his knowledge to the students who succeed him, thereby advancing both hospital and general pharmacy

serums are used in hospital work and it is imperative that the intern understand their uses and the proper methods of storage.

This routine should be followed for the first few weeks, during which time the intern will become familiar with the stock of the drug room. At the same time, the pharmacist will have time to observe the deficiencies of the intern and thus be in a better position to correct them by altering his method of supervision to meet the various situations.

A knowledge of new and non-official drugs that are often in demand in hospitals should be included in the training of the intern. The use, as well as the effect and medicinal value, of each drug must be thoroughly explained. Often a doctor reads or hears of a new drug purported to be beneficial in certain cases and turns to the hospital pharmacist for full details. Hence, if the intern is prepared to discuss these new drugs intelligently and completely, he will command the doctor's respect.

After the intern has learned the routine work, he should be taught to fill prescriptions for clinic and house patients. At first he merely reads the prescriptions and tells how he would fill them. The pharmacist must point out all incompatibilities and show the intern how to overcome them.

In the filling of prescriptions the pharmacist is given his best opportunity to aid the intern. Doses can be closely studied and discussed. Any

mathematics involved is left for the intern. As soon as he is able to read and detect incompatibilities and check doses and, in general, has a good understanding of prescription filling, the intern may be allowed to fill prescriptions. But, the pharmacist must check all of them to make sure that they are filled properly. Labeling is also an important factor since incorrect labels may do serious harm not only to the pharmacist but to the patient.

In many hospitals, the pharmacist must prepare the intravenous solutions used daily. It is necessary for the intern to understand the preparation, testing and storage of the different solutions. He should be allowed to help the pharmacist prepare and test them.

More and more responsibility should be given the intern. Since narcotics are important, the pharmacist must teach the intern their use and proper handling. Although the actual dispensing and checking of narcotics are never left to the intern, he should learn how to keep records. He should also know the laws and regulations governing the buying, dispensing, recording and storing of all narcotics.

The pharmacy intern should prepare a formulary for himself of the special prescriptions and solutions used by certain doctors. He should also include the various solutions used in the different departments of the hospital.



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NOTES AND ABSTRACTS

By Carl C. Pfeiffer, M.D., Department of Pharmacology
University of Chicago

Local Anesthetics

• Einhorn who in 1905 introduced the first synthetic local anesthetic, procaine (novocaine), did such a thorough job that the only important contributions since that time have been in compounds that are potent surface anesthetics and may also be used for infiltration anesthesia.

A list of the useful local anesthetics should probably include those listed in the accompanying table. They are arranged in the order of increasing toxicity as determined by subcutaneous dosage in guinea pigs: the toxicity is presented as the safe total dose for each compound that may be injected in the human being.

Infiltration and Spinal Anesthesia

Procaine HCl	U. S. P.	400 mgm.
	(novocaine)	
In spinal anesthesia not over 200 mgm.		

Surface and Infiltration Anesthesia

Metycaine	N. N. R.	300 mgm.
Larocaine	N. N. R.	200 mgm.
Panthesin	N. N. R.	125 mgm.

Surface Anesthesia

Tutocaine	N. N. R.	200 mgm.
Butyn	N. N. R.	75 mgm.
Phenacaine	N. N. R.	60 mgm.
Cocaine	U. S. P.	60 mgm.
Pontocaine	N. N. R.	30 mgm.
Nupercaine	N. N. R.	15 mgm.

Rules of Local Anesthesia

• 1. Because of the unfortunate similarity between the pronunciation of cocaine and procaine the nursing staff should be taught *never to supply cocaine for injection*.

2. Never use anything but procaine for spinal anesthesia.

3. Never use more than from 150 to 200 mgm. of procaine for spinal anesthesia.

4. Never use spinal anesthesia in the presence of debilitation, diseases of the central nervous system or nervous instability.

5. Carefully avoid intravenous injection of any local anesthetic.

6. Do not attempt local surface anesthesia in a urethra traumatized by recent instrumentation.

7. Never use more than 1:25,000 epinephrin with the local anesthetic. Do not use epinephrin in thyrotoxicosis or in the digits of patients with hypertension.

8. Excess needle trauma is the greatest factor in tissue necrosis and delayed wound healing after infiltration anesthesia.

9. Avoid reactions by premedication with the hypnotic dose of a short-acting barbiturate two hours before the operation.

10. Treat reactions with short-acting barbiturates, which may be given intravenously, if necessary, to control convulsions.

Procaine in Sprains

• Since the introduction by Leriche of Strasbourg in 1933 of the use of from 1 to 2 per cent procaine in the treatment of sprains, there has been considerable controversy in medical circles over the use of this procedure. Its proponents, who are Campbell and Moznahan of England, Arnulf and Frieih of France, and Ware, Weissman and Lozan of this country, report that not only is the pain decreased but the swelling is also reduced.

The greatest criticism has come from its use in the treatment of athletic injuries (usually sprains) in which the patient is allowed to participate in competitive sports before healing can have taken place. The crux of the controversy seems to rest on the as yet unanswered question as to whether a sprained member requires immobilization (effectively produced by pain) for adequate and permanent healing.

The sensible answer to this problem is to treat this type of anesthesia as one would any other, *i.e.* independently of the surgical or pathologic condition; that is, the patient should be kept at rest until all objective signs of the injury have disappeared. The anesthetic is thus used to eliminate pain, while the healing is not judged by the absence of pain but rather by the trained critical senses of the attending physician.

Spinal Anesthesia

• Because of the varying morbidity of spinal anesthesia (from 1:500 to 1:10,000) under changing conditions of operators and the anesthetic used, many hospitals have been prone to discontinue spinal anesthesia in their operating rooms. While nothing is more pathetic than a permanently paralyzed patient, this hazard can be minimized by using only experienced operators

for the production of spinal anesthesia and by the strict observance of the rules of local anesthesia. It has been shown by analysis of morbidity statistics that the largest single factor in the reduction of morbidity resulting from spinal anesthesia is the technic of the operator. When the technic is perfect and procaine only is used, the morbidity compares favorably with that of ether anesthesia and the postoperative complications are perhaps fewer than those that follow ether anesthesia.

Shock During Spinal Anesthesia

• The drop in blood pressure that occurs within twenty minutes after the induction of anesthesia is generally believed to be due to the relaxation of the voluntary and arteriolar smooth musculature of the lower extremities and splanchnic areas. Many nervous individuals and patients with functional disorders have a diminished circulatory volume (high hematocrit and serum protein), which is adequate only because of intense vasoconstriction. With relaxation, owing to the anesthetic, the patient suffers relative cerebral anoxia with concomitant nausea, vomiting and headache. This is best combated by the intravenous administration of Ringer's solution; or temporary relief may be obtained by the intramuscular injection of neosynephrin HCl (10 mgm.) or ephedrine HCl (50 mgm.).

The determination of any increase in the hematocrit or serum protein before anesthesia would be of value in that some anesthetic agent, such as cyclopropane which tends to raise or maintain arteriolar tone, could be substituted for the proposed spinal anesthetic.

Hospital Pharmacy Course

A seminar course in hospital pharmacy will be offered this fall for the first time to students in the school of pharmacy at Purdue University, Lafayette, Ind. The course includes lectures, laboratory preparations and tests, including the sterilization, pH and tonicity of solutions such as collyria, inhalants and various types of parenterals. Stress is laid on the supervision and economics of the hospital pharmacy.

"Fitting" Bottle Covers

It might be well to start a campaign to standardize the size of the openings and covers for bottles. Most hospital pharmacists wash and reuse all available bottles and nothing is more maddening than a cover that "almost fits." —EDITH BLANCHE WILLIAMS, *pharmacist, Bryan Memorial Hospital, Lincoln, Neb.*

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Monthly News Review

Vol. 53

September 1939

No. 3

New York Hospital Plan Modifies Contract; Drops Single Memberships

Modifications in its contract and the cancellation of 57,000 contracts with subscribers who enrolled individually were announced by the Associated Hospital Service of New York on August 14. The changes were made in order to counteract or limit the rising utilization ratio that has been experienced by a large number of the hospital care insurance plans.

Principal changes were in maternity benefits, which are now restricted to those persons with full family contracts, and in the use of special services, which were limited to definite cash maximums, \$20 or \$25 in most instances. The period of hospital stay is shortened from 30 to 21 days and the discount on the bill beyond this period is reduced from 33⅓ per cent to 25 per cent and is limited to a period of 60 days. Restrictions are imposed upon service for tonsil and adenoid cases. The list of exclusions is increased and emergency service for ambulatory patients is not covered.

The subscribers whose contracts have been cancelled will be given an opportunity to apply for reenrollment under a new agreement on an individual basis at slightly higher rates provided their personal medical history is good. Rates for husband and wife contracts are also increased to double the rate for the single individual.

The association recently filed with the New York State department of insurance a financial statement showing a surplus to subscribers of \$568,000 as of June 30 and a reserve of over \$1,000,000. Reduced rates of payment to hospitals are still in effect but it is hoped the old rate can be restored.

A reorganization of the office of the Chicago Plan for Hospital Care has been completed, according to a recent statement issued by the plan. Four major divisions have been established: comptroller, financial, promotion and hospital service. The reorganization, it is said, has permitted a 25 per cent reduction of staff. Although all promotion was stopped on April 19, reenrollments and instances in which companies took the initiative served to add 5000 members a month during May, June and July.

Coming Meetings

Sept. 15-16—Institute for Hospital Administrators, University of Chicago.
Sept. 11-15—American Congress on Obstetrics and Gynecology, Cleveland.
Sept. 19-23—International Hospital Association, Royal York Hotel, Toronto.
Sept. 21-22—Canadian Hospital Council, Toronto.
Sept. 23-24—American Protestant Hospital Association, Toronto.
Sept. 24-25—American College of Hospital Administrators, Toronto.
Sept. 25—American Occupational Therapy Association, Toronto.
Sept. 25-29—American Hospital Association, Toronto.
Sept. 26-29—National Association of Nurse Anesthetists, Toronto.
Oct. 16-20—American College of Surgeons, Philadelphia.
Oct. 26-28—National Society for the Prevention of Blindness, Astor Hotel, New York City.
Nov. 20-21—Alberta Hospital Association, Edmonton, Canada.
Dec. 1-2—Kansas State Hospital Association, Jayhawk Hotel, Topeka.
Feb. 22-24—Texas Hospital Association, San Antonio.
March 7-9—New England Hospital Association, Hotel Statler, Boston.
March 28-30—Southeastern Hospital Conference, Edgewater Gulf, Biloxi, Miss.
April 2-4—Ohio Hospital Association, Columbus.
April 5-7—Carolinas-Virginias Hospital Conference.
April 8—Tennessee Hospital Association, Chattanooga.
April 8-11—Association of Western Hospitals, Hotel Biltmore, Los Angeles.
April 11-12—Mid-West Hospital Association, Kansas City, Mo.
April 17—Alabama Hospital Association, Birmingham.
April 22-24—Iowa Hospital Association.
May 1-3—Tri-State Hospital Assembly, Hotel Stevens, Chicago.
May 8-10—Hospital Association of Pennsylvania, William Penn Hotel, Pittsburgh.
May 22-24—Hospital Association of the State of New York, Buffalo.
May 23-25—Minnesota Hospital Association, Minneapolis.

Sisters to Be Entertained at Toronto

Catholic Sisters who attend the American Hospital Association convention in Toronto will find that a special program of entertainment has been provided for them. On Tuesday, September 26, a reception will be held at St. Joseph's Convent; Wednesday there will be a trip to the Martyr's Shrine, and on Thursday and Friday, visits to St. Michael's and St. Joseph's hospitals have been arranged.

Build Free Medical Clinic

Construction was started July 1 for the first unit of the free medical clinic of Mount Sinai Hospital, Los Angeles. The \$250,000 unit will be built in the city's most heavily inhabited district. Completion is promised by October 1.

First American Congress on Obstetrics, Gynecology to Be Held in September

The first American Congress on Obstetrics and Gynecology will open in the Cleveland public auditorium on September 11 and will continue through September 15. The congress will be divided into four sections: medical, public health, nursing and institutional administrators.

Among the subjects to be discussed at the opening session of the administrators' section are "Obstetric Practice in Hospitals by the General Practitioner," by L. J. Pickard, M.D., Hendrick Memorial Hospital, Abilene, Tex.; "Procedure for Reducing Maternal Mortality in Obstetric Divisions of the General Hospital," James W. McGill, M.D., Superior, Wis., and "Obstetrical Service in the General Hospital v. Maternity Hospital Service," by Charles E. Gaupin, M.D., SS. Mary and Elizabeth Hospital, Louisville, Ky.

On Tuesday Robert J. Hawkins, M.D., Loyola University School of Medicine, Chicago, will speak on "Present and Prospective Developments in Delivery Room Equipment," and Sister M. Irenaeus, superintendent of the Providence Hospital, Beaver Falls, Pa., will talk on "Adequate Facilities for Obstetrical Service in the Small Rural Hospital." The question of providing for maternity care in group hospitalization plans will be discussed by Ray F. McCarthy, executive director of Group Hospital Service, Inc., St. Louis, at the Thursday meeting. On Friday the administrators will meet jointly with the nursing section to consider standards of nursing service.

Both scientific and technical exhibits will be on display during the meeting.

New Wing Lacks Furnishings

The new \$50,000 women's and children's addition to the Santa Barbara County General Hospital, Calif., which has been ready for occupancy for several weeks, remains empty because of lack of funds to purchase furnishings. The new wing has space for 36 beds on the ground floor and 36 on the second floor. No reply has been made to an application to the P.W.A. for a \$3000 allocation toward the \$9000 that will be required to furnish it.



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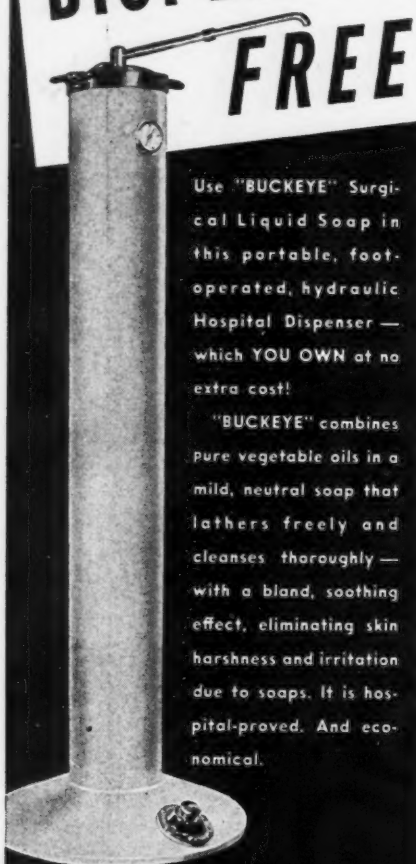
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Interesting Program Will Be Presented at Toronto by Nurse Anesthetists Group

Nurse anesthetists from the United States and Canada will find an outstanding program at their annual convention which meets from Tuesday through Friday at Toronto, in conjunction with the American Hospital Association meetings.

Tuesday morning and afternoon will be devoted to business meetings and the evening to a banquet at the King Edward Hotel with Hugh Eayrs, president, of the MacMillan Publishing Co. of Toronto, as guest speaker.

At the Wednesday morning session Joseph G. Norby, administrator, Columbia Hospital, Milwaukee, will discuss "The Value of a Well-Organized Anesthesia Service"; John R. Mannix, executive director, Michigan Society for Group Hospitalization, will talk on "Cooperative Action in the Health Field," and Dr. James Graham, attending surgeon and consulting anesthetist of St. John's Hospital, Springfield, Ill., will outline the physiology of anesthesia.

The afternoon session will deal extensively with the subject of cyclopropane. Serena Huntimer of San Francisco will compare cyclopropane and ether and Katherine Jurgenson of Minneapolis will give a report on 6000 cases in which cyclopropane was used. Dr. Forest Young of Strong Memorial Hospital, Rochester, N. Y., will speak on "Repeated Dosages of Avertinin Plastic Surgery" and Dr. Warren P. Morrill of the American Hospital Association will summarize information on the prevention of anesthesia explosion hazards. An instructors' session will be held at 4:30.

Thursday morning's session will open with a paper by Dr. Myra Babcock of Grace Hospital, Detroit, on "Preoperative Medication and Postoperative Treatment." Dr. V. E. Henderson, professor of pharmacology and toxicology at the University of Toronto, will discuss the anesthetists' service to mankind; Dr. Robin C. Buerki, chairman, council on professional practice of the American Hospital Association, will present the principles of relationship between anesthetists and hospitals, and Dr. Frederick R. Mautz of the University Hospitals, Cleveland, will discuss resuscitation in the operating room.

A joint luncheon of alumni associations at noon, a business session in the afternoon and a series of four clinics on Friday morning will close the session.

A golf tournament for the Ontario Hospital Association Cup will be held at St. Andrew's Golf and Country Club, Toronto, on September 27. Competitors should obtain entry cards at the registration desk.

Operation of Group Medical Plans to Be Standardized

Creation of a national organization to standardize methods of operation of prepayment plan medical groups was voted at the closing session of the convention of Group Health Plans held in New York City recently. Winslow Carlton, executive secretary of the Group Health Association of New York, was chosen as chairman of the organizing committee. Other members of the organization committee are: Dr. Mahlon Ogden of Trinity Hospital, Little Rock, Ark.; Dr. H. Clifford Loos of the Ross-Loos Medical Group, Los Angeles, and Perry Taylor, administrator, Group Health Association of Washington.

The first annual meeting of the new unit will be held in Chicago in 1940. Dr. Hugh Cabot of the Mayo Clinic and Dr. John P. Peters of Yale University school of medicine were among the speakers at the convention. Doctor Peters declared that group medicine might lead the way not only to better community health but also to the restoration of idealism and the spirit of investigation in organized medicine.

Standards for Ophthalmologic Care

A new set of standards for outpatient ophthalmologic departments has been published in mimeographed form by the Welfare Council of New York City. The 18 page pamphlet summarizes in concise form the desirable standards for three departments of ophthalmologic care: medical service, nursing service and medical social service. It is the result of five years' work by outstanding New York authorities.

N. J. Hospital Plan Reaches 150,000

The Hospital Service Plan of New Jersey has reached a new peak in growth with a total membership exceeding 150,000 subscribers. This represents an increase of 34 per cent in net active gain since January 1, and 185 per cent over the enrollment of one year ago.

QUIET IS SO IMPORTANT!...

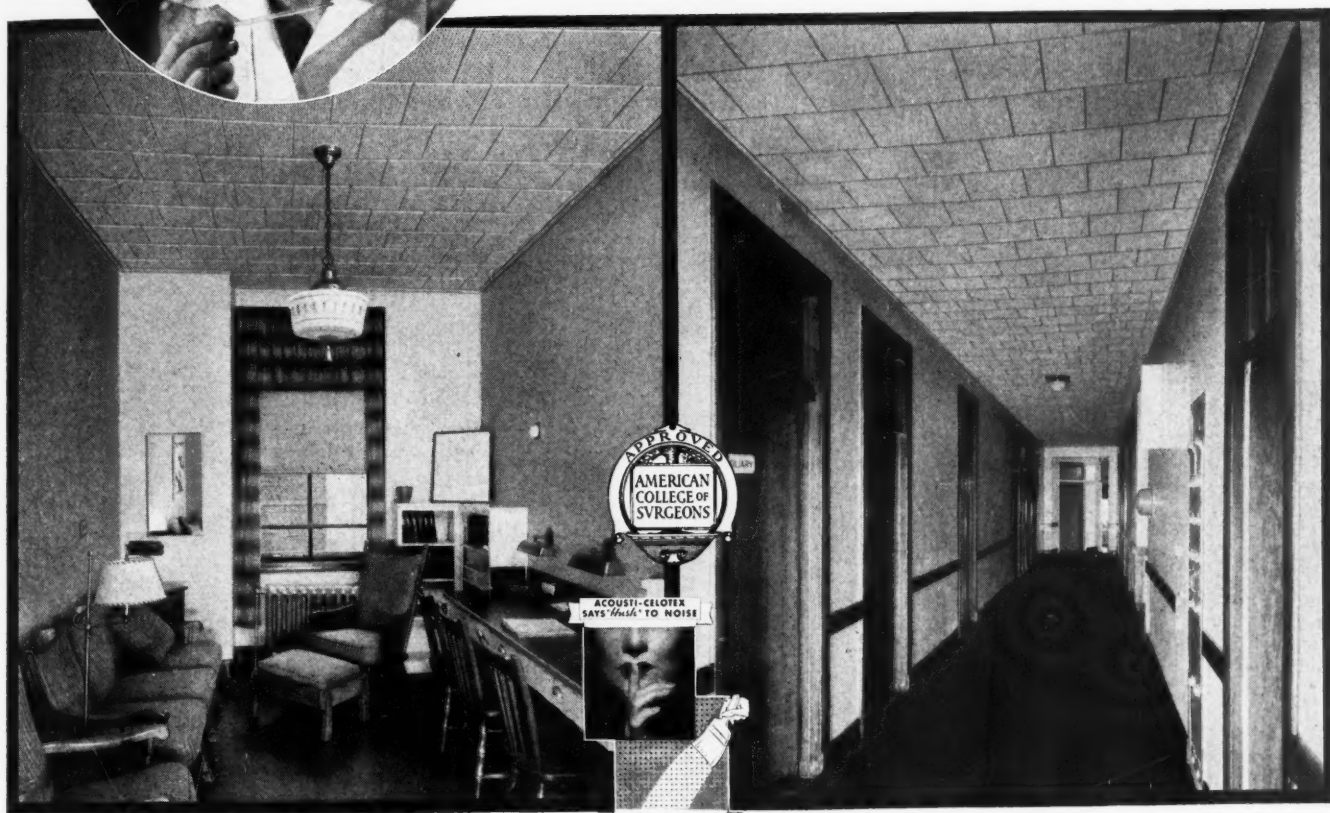


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Englewood, New Jersey, Hospital Safeguards Comfort of Patients with Paintable Sound-Quieting Ceilings

NATURALLY there will be conversation in the nurses' station in any hospital—and you can't guard against footsteps and voices in the corridors. But what you *can* do, and very easily, is to install noise-hungry Acousti-Celotex Fibre Tile in the ceilings of all noise sources to hush echoes and subdue sound.

This material is ideal for hospitals, because no amount of painting will lessen its acoustical efficiency. *Easily applied over existing ceilings in a short time and at moderate cost*, this method of sound-

quieting is now delighting nurses, doctors, and patients in hundreds of hospitals.

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Please have a Celotex Acoustical Expert see me about a **FREE Noise Survey** of our hospital. Also send your valuable booklet, "NOISE," and your magazine, "QUIET FORUM."

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CANNED FOODS AND HUMAN ENERGY REQUIREMENTS

● An adequate supply of food energy is one of a number of nutrient requirements of man. Fortunately, all nutrients—with the exception of water, minerals and accessory factors—supply chemical energy which the body can utilize to support muscular activity and life processes. Individual foods will, however, vary in the extent to which they supply food energy.

The energy requirements of man and the caloric values of foods have long been fields of active investigation. Energy requirements are measured in terms of a heat unit, the calorie. Many researches (1) show that human caloric requirements are variable and influenced by a number of factors.

During periods such as infancy, childhood, pregnancy and lactation, or during convalescence from wasting illness, energy-yielding nutrients are required both for support of body activity and for tissue formation. However, for the average adult, food energy intake should balance energy expenditure. For adults, variation in activity is the chief factor influencing variation in energy requirement; age, sex, size and body build being comparable. Sedentary occupations may require a food energy intake of 2500 calories per day; 5000 calories might be necessary if the individual engaged in strenuous muscular activity. Close approximations are available for the probable food energy requirements of individuals during different stages of the life cycle and engaged in various activities (1, 2).

Experiments (3) have also demonstrated that oxidation of foodstuffs in the animal body—due allowance being made for the energy contents of the end-products of oxidation—yields the same number of cal-

ories as are produced by the oxidation of similar foodstuffs in the combustion type calorimeter. Since the potential food energy of foodstuffs resides in their contents of carbohydrates, fats and proteins, the available calorific value of any food may be readily calculated (4) by using the factors 4, 9 and 4 calories per gram of these respective nutrients. Of these food components, the carbohydrates and fats are those which contribute most towards attainment of our varied, food energy requirements. Reliable tables are available (5) which list the calorific contributions of most common foods.

It has been established first, that foods—principally by virtue of their carbohydrate and fat contents—contribute energy for use by the human body; and second, that the human energy requirement is conditioned by many factors and may vary widely. An adequate supply of food energy is, of course, one of the necessary objectives of proper nutrition. However, individual attributes such as vitality, strength or endurance are influenced by—but not solely dependent on—proper nutrition, in which adequate food energy is supplied.

The food energy values of commercially canned foods are essentially those of the raw materials from which they are prepared. In some instances, the natural caloric values of the raw foods may have been enhanced by the medium in which they were packed, for example, carbohydrate-bearing syrups or sauces used in the canning procedure. Consequently, since canned foods include products of both high and low caloric intakes, such foods are valuable in formulating diets to supply any intake of food energy which might be desired.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

1. 1938. Nutrition Abstracts and Review. 7, 509.
2. 1933. U. S. Dept. Agr. Circular No. 296.
3. 1931. The Elements of the Science of Nutrition, Fourth Edition, Graham Lusk, Saunders Co., Philadelphia, pp. 61-74.
4. 1938. Chemistry of Food and Nutrition, Fifth

- Edition, Henry C. Sherman, Macmillan Co., New York, pp. 150.
5. 1931. U. S. Dept. Agr. Circular No. 146.
1931. U. S. Dept. Agr. Circular No. 50.
1935. Dietetics for the Clinician, Second Edition, M. A. Bridges, Lea & Febiger, Philadelphia.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the fifty-first in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

A.C.S. Announces Varied Program for Hospital Standardization Meeting

The plans for the twenty-second annual hospital standardization conference of the American College of Surgeons, to be held at the Bellevue-Stratford Hotel in Philadelphia October 16 to 19, reveal a diversified program.

Demonstrations of many phases of hospital operation will be held in Philadelphia hospitals on the afternoons of October 18 and 19. These will include blood bank and blood transfusion management and procedures, pediatric nursing care, out-patient clinic management, methods of follow-up, maternal care, anesthesia, food service, physical therapy, nursing and operating room technics, and other features of hospital administration and service.

General themes, which will each be the subject of several papers and of panel or round table discussions, will include: "The Medical Staff: Its Organization and Function"; "The Organization and Management of the Small Hospital"; "Problems Pertaining to Various Phases of Hospital Administration in the Large Hospital," and "Pertinent Hospital Problems." The last topic will be covered in an evening round table conference.

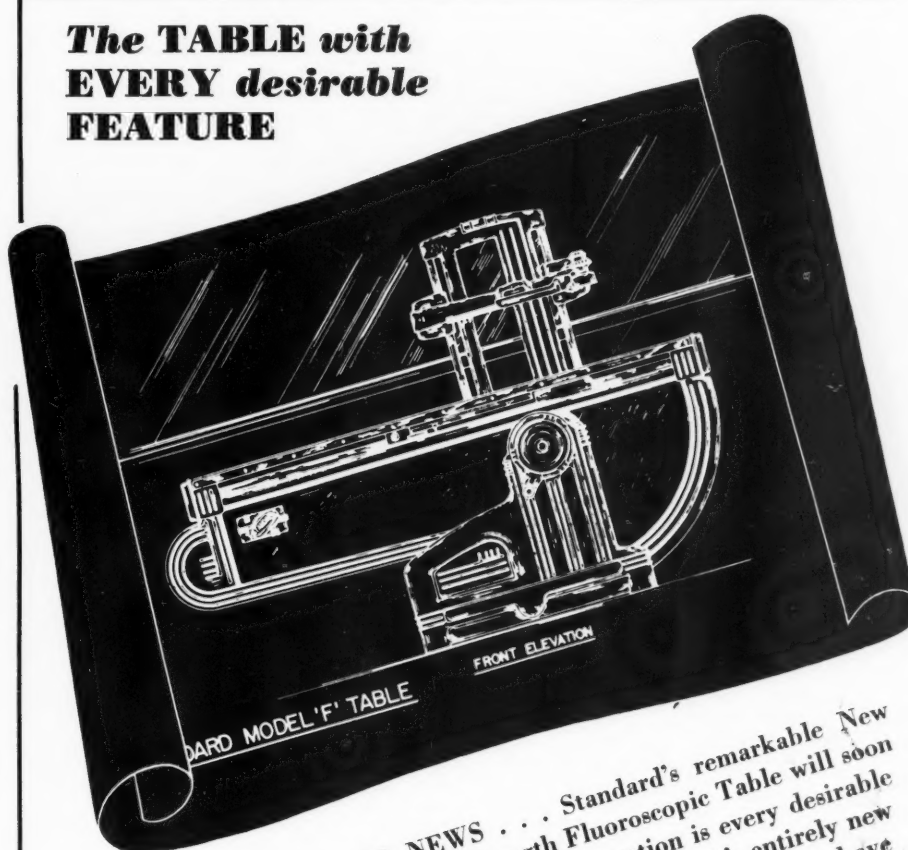
Leaders in organized hospital and medical work will be among those who will address the conference on special subjects. The president of the Catholic Hospital Association, Rev. Alphonse M. Schwitalla of St. Louis, will discuss "The Preservation of Our Present Voluntary Hospital System." The incoming president of the American Hospital Association, Dr. Fred G. Carter of Cleveland, will talk on "Educated and Trained Personnel Essential for Maintaining Proper Standards of Service in the Care of the Hospitalized Patient." The president-elect of the American College of Hospital Administrators, James A. Hamilton of New Haven, will present his views on "The Education and Training of the Modern Hospital Administrator." Dr. Robin C. Buerki of Chicago will describe "The Rôle of the Hospital in Graduate Education for the Physician or Surgeon Desirous of Proper Preparation for His Specialty." The chairman of the Committee on Graduate Training for Surgery, American College of Surgeons, Dr. Dallas B. Phemister, professor and chairman of the Department of Surgery, University of Chicago school of medicine, will outline "Present Trends in Graduate Training for Surgery." Dr. Harvey

Agnew of Toronto, president of the American Hospital Association, will discuss "The Importance of an Efficient Medical Staff to a Hospital."

Among the other topics that will be discussed by authorities prominent in each field will be: "Diet as Related to Surgical Convalescence," by Dr.

Charles B. Puestow of Chicago; "The Hospital Trustee," by Raymond P. Sloan of New York; "The Small Hospital," by Charles A. Lindquist of Elgin, Ill.; "Tumor Units in General Hospitals," by Dr. Joseph Tenopir of Brooklyn, and "Relationships Between Hospitals and Radiologists, Pathologists and Anesthetists," to be discussed respectively by Doctors B. R. Kirklin of Rochester, Minn., Frank Hartman of Detroit and Emery A. Rovenstine.

The TABLE with EVERY desirable FEATURE



HERE IS GOOD NEWS . . . Standard's remarkable New Shockproof Tilting, Full Length Fluoroscopic Table will soon be available to you. Incorporated in its construction is every desirable feature—many features not found in any other table. It's entirely new in principle, convenient, dependable. It is the table that you have wanted but couldn't buy. Write today for complete, descriptive illustrated information, specifications, quotations.

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Send also information and complete catalog of all Standard equipment.

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M-H

Senate Group Reports on Proposed Amendments to Wagner Health Bill

Amendments to the Wagner Health Act will be prepared "to assure that federal aid will require unequivocally clear showing of need through impartial state and local surveys and clear satisfaction of federal requirements that such needs exist, in addition to reasonable demonstration as to future continuing support of the hospitals," according to a preliminary report recently published by the committee on education and labor of the United States Senate.

The committee stated that it was studying the methods of financing needed hospital construction and expected to have further conferences with representatives of hospital organizations to discuss various problems concerning hospital needs and services.

The committee is also agreed, the report states, that the bill should be amended by addition of positive provisions that qualified hospitals and agencies, both public and private, may be utilized in the state plans for health and medical services.

The committee reported that the

national health bill has received wide support from large and representative organizations and that the committee is convinced that federal legislation along the general lines of the bill is necessary to strengthen the health services of the nation and to make provision for the progressive and effective improvement of health conditions in all parts of the country and among all groups of people. "The committee is prepared to augment the provisions of the bill, if additional provisions are needed, to assure that the amount of federal assistance will in no instance be in excess of clearly demonstrated need," the report states. Continued study is promised so that a definitive report can be submitted to Congress for its consideration soon after the beginning of the next session.

WIVES ARE WELCOME

An interesting program is being planned for the women accompanying their husbands to the convention. There will be teas, receptions, drives, a banquet and a ball, and a musicale as well as other entertainment

Public Health Service Will Lend Radium to Hospitals

The National Cancer Institute of the U. S. Public Health Service, after consultation with state departments of health, has recommended that about 8½ grams of government-owned radium be lent to various hospitals in 20 states and the Territory of Hawaii.

The Cancer Institute bases its approval for the loan of the radium upon the need for radium, upon the staff and upon the adequacy of facilities for radium treatment. Approximately 1300 milligrams of radium have not yet been allotted and applications for loans will continue to be considered.

Institutions receiving the government-owned radium have to agree to make no charges to the patients for its use and to meet high standards regarding the personnel.

Graduate Course for Negro Doctors

A postgraduate course for Negro physicians was held from June 19 to July 1 at Flint-Goodridge Hospital of Dillard University in New Orleans. Thirty-five physicians from six states and from the Spanish Honduras were registered for the course.

NEW FOOD

SENSATION!

COMBINING TWO OF THE WORLD'S MOST POPULAR FLAVORS

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Delicious Rich **CHOCOLATE** and

Nutty **WHOLEWHEAT** Flavor

● Another famous FIXT product has made its bow and wherever served has been an instant success. Consisting of the finest chocolate, milk, and specially prepared whole wheat flour, this new food dessert is going over in a really big way — and — it's as healthfully rich in vitamins as it is delicious.

To prepare, just add water and boil — the milk, in generous quantity, is already in it.

Your patients of all ages will love this healthful, satisfying food dessert.

Consult your jobber, or write direct (on your letterhead) to FIXT Products, Dept. MH, 1170 Broadway, New York for sample and complete details.

Write for our helpful Booklet "76 FIXT Recipes." Address FIXT Products, Department MH, 1170 Broadway, New York City



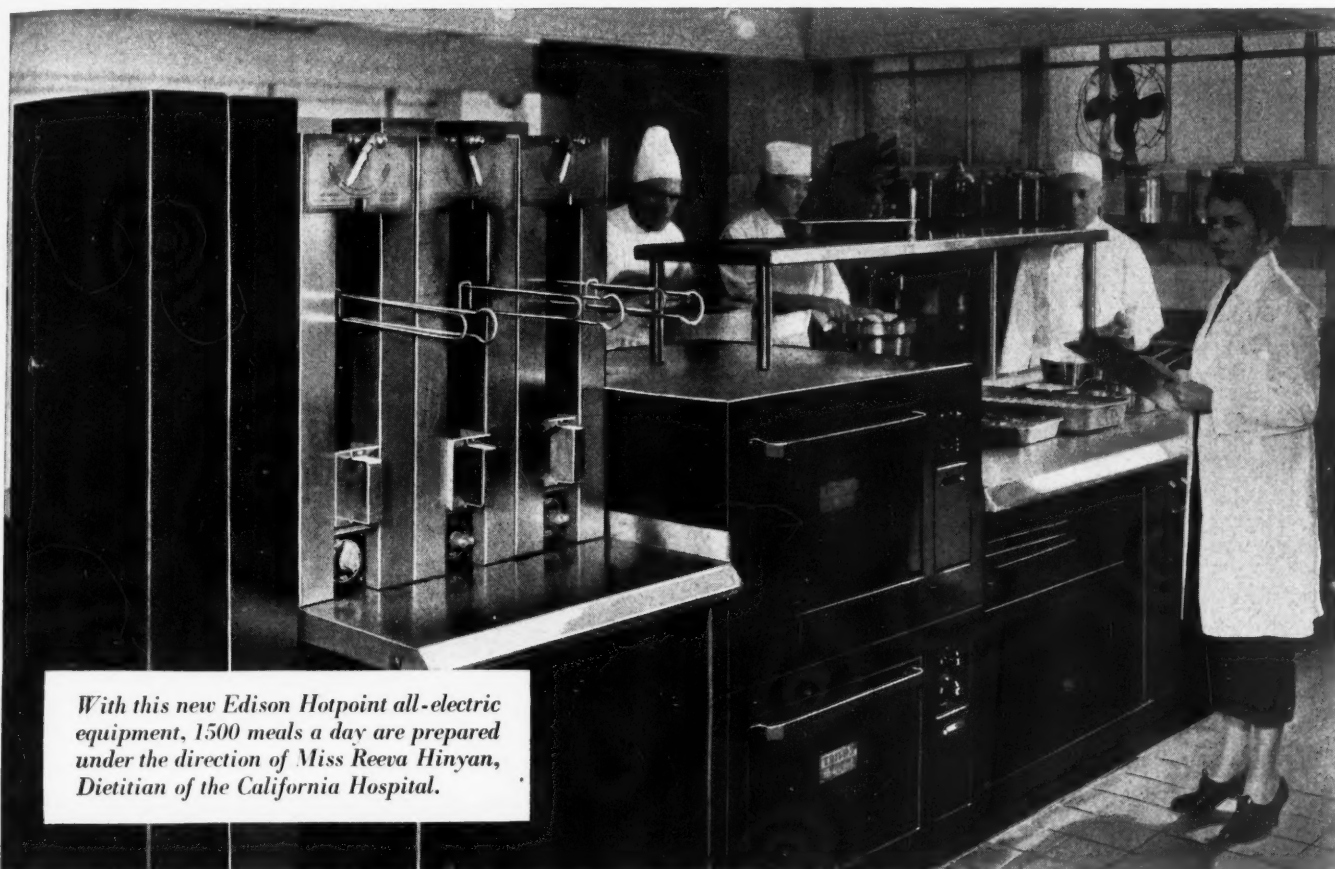
FIXT Whole Wheat Chocolate Pudding



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Electric Kitchen Superiority

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With this new Edison Hotpoint all-electric equipment, 1500 meals a day are prepared under the direction of Miss Reeve Hinyan, Dietitian of the California Hospital.

● Two gruelling years of punishment and the Edison Hotpoint Electric Kitchen in the California Hospital is still delivering its original, economical and service-free operation. True proof of Edison Hotpoint superiority.

Miss Reeve Hinyan, Dietitian for patients of both the California Hospital and the children's department conducted as the California Babies Hospital, says, "Hospital patients are hard to please in the matter of food menus. Nourishing food is essential, but it is a problem to stimulate appetites. We feel that our all-electric kitchen has improved our cooking, and made foods more appetizing."

The decision to replace other fuel with electricity was the result of careful investigation and comparison. The hospital management carefully studied equipment and

operating costs. Above all, the *results* of electric cookery were analyzed, since nourishing food is vital to patients.

R. E. Heerman, Superintendent of the California Hospital states, "Sound business principles had much to do with our decision to install an all-electric kitchen. We believe that our electric equipment will outlast other types. Operating costs are in line, and an electric kitchen saves in maintenance expense."

Investigate the Edison Hotpoint all-electric kitchen. Edison Hotpoint equipment makes your kitchen as modern and efficient as your operating room. See your local electric company or write for complete information.

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Hotpoint

COOKING
EQUIPMENT

Incidence of Illness Among New York City Hospital Nurses Rises

A study of resignations in the division of nursing made by the department of hospitals of New York City to ascertain the causes of turnover in nursing personnel revealed that of 877 resignations in 11 hospitals for 1936-37, 15.14 per cent were for health reasons, Dr. S. S. Goldwater stated in his annual report to Mayor LaGuardia. Anticipated effects of the recently instituted eight hour day on the health of graduated nurses have not been realized; under the eight hour day illnesses and absences have decidedly increased.

In order to reduce the turnover health programs were extended to all hospitals, an increased number of no-maintenance positions were provided and increment salary schedules were requested.

During 1938 individualized patient care was accentuated by the nursing division in an effort to break down the mass treatment devised to give essential care in the least possible time. The objective was to modify routine nursing

measures according to individual nursing.

In the last five years the division of nursing has expanded, Doctor Goldwater reported, until in 1938 its personnel included 5026 graduate nurses, 2091 attendants, 946 student nurses, 359 extra-departmental affiliate students and 47 practical nurse students.

Escaped Convict Kills Nurse, Wounds Hospital Administrator

Mrs. Hattie Hooker, a nurse at the Good Samaritan Hospital, Portland, Ore., was killed and Dr. C. H. Manlove, superintendent of the hospital, was wounded when a fugitive from the Washington State Prison attempted unsuccessfully to escape from the hospital on August 19. The convict, Hulen Presley, had been wounded when he fled from a holdup and had been taken to the Good Samaritan Hospital for treatment.

Presley leaped out of bed and wrested the gun from the policeman who was guarding him; he then raced down the corridors of the hospital firing indiscriminately. One bullet struck Mrs. Hooker in the head and another nicked Doctor Manlove's knee.

Welfare Council Begins Chronic Disease Campaign; Studies Sickness Trends

Dr. Ernest P. Boas, chairman of the Welfare Council of New York City's committee on chronic diseases, has announced an intensive campaign to bring to the attention of medical and public health authorities the need for combating chronic illness. "Chronic diseases are ever present and inescapable," Doctor Boas asserted. "They occur at all ages."

To stimulate public interest in the campaign, the Welfare Council has placed on exhibition at the Grand Central terminal a model of "A Chronic Disease Hospital and Health Center of Tomorrow," which illustrates how a community must plan to control chronic diseases.

Another activity announced by the Welfare Council is the publication of a classified list of diagnoses of sickness in 113 New York hospitals during the course of an entire year. This is the first step in an effort to make possible reliable reporting of sickness and disease trends in New York City and is being carried on by the research bureau.



Deknatel Hospital and Surgical Products are made in U.S.A.

DEKNATEL EYELESS NEEDLE

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MORSETHALER BED

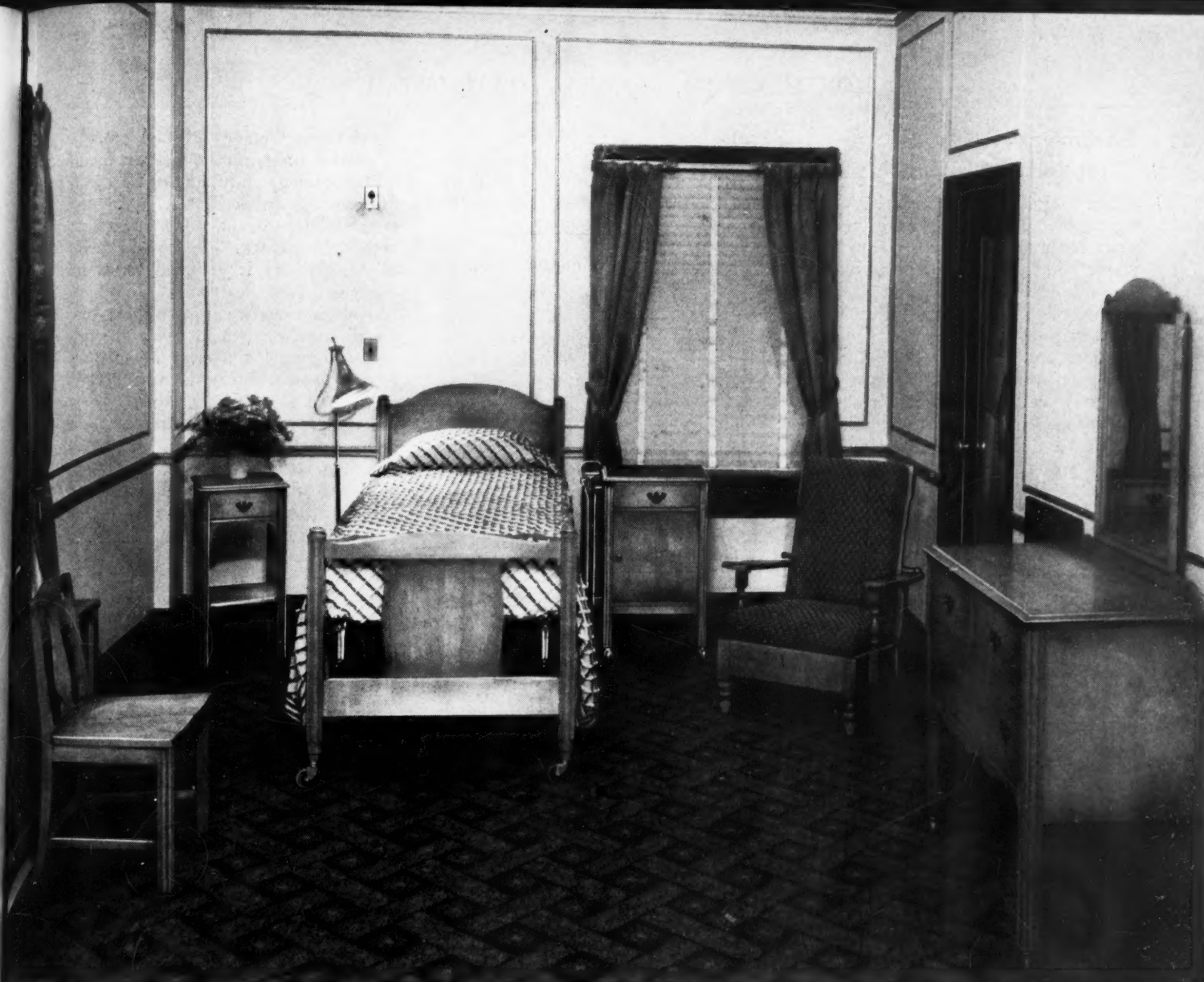
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You CAN DUPLICATE THIS ROOM FOR LESS THAN \$135

The most outstanding value ever offered in the hospital field! The complete furniture group illustrated above costs only \$132.50. Each piece of furniture is of solid hard rock maple finished in a soft strained honey color, with a special acid, alcohol, and germicide protective finish. The adjustable gatch spring, the side arm on the bed side cabinet, and the casters

are of the absolute highest quality. Each piece of furniture is made strong and durable by complete dove-tail construction and masterful craftsmanship throughout. The simplicity of design lends a pleasant, conservative, home-like atmosphere, blending with the soft mellow tone finish which adds a cheerful touch . . . and completes all the requisites of a deluxe private room.

PURCHASED SEPARATELY, THE COST OF THE FURNITURE IS \$143.25:

Bed complete with Gatch Spring and 3" Casters.....	\$42.00
Dresser with Mirror.....	31.50
Bedside Cabinet with Tray Shelf.....	32.00
Straight Chair.....	6.00

Easy Chair (Sun and Tub Proof Removable Slip Covers in choice of Green, Blue or Rust).....	\$21.00
Bedside Table.....	10.75

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MH 5

Government Funds Allocated for Venereal Disease Control

The federal government will allocate the sum of \$4,379,250 to the various states for venereal disease control programs during the coming twelve months, it has been announced.

The federal allotment, which will be supplemented by state and local appropriations and by grants from foundations and other private organizations, will represent a larger sum than heretofore has been available for combating venereal disease. Doctor Parran pointed out, however, that the available funds do not even approximate the amount that is considered necessary for the most effective public health campaign.

In order to receive federal grants, the states must meet certain general minimum requirements in the prevention, treatment and control of the venereal diseases.

Laundry Managers to Convene

Hospital and institutional laundry managers have been invited to attend the first national convention of the Institutional Laundrymen's Association in Atlantic City, N. J., from September

29 to October 1. Brig. Gen. A. B. Warfield, in charge of all quartermaster corps laundries of the Army, will address the meeting.

Calvin Heads Minnesota Plan

Arthur M. Calvin, administrator of the Midway and Mounds Park Hospitals, St. Paul, has been elected executive secretary of the Minnesota Hospital Service Association to succeed E. A. van Steenwyk. Mr. van Steenwyk resigned last year to accept a comparable position with the Associated Hospital Service of Philadelphia but has served as executive of both plans until a successor was selected. Mr. Calvin was the first president of the Minnesota Hospital Service Association, has been president of the American Protestant Hospital Association and has been active in the committee work of the American Hospital Association. The Minnesota Hospital Service Association is the second largest hospital care insurance organization in the United States. In July the association hospitalized its fifty thousandth patient. It now provides service in the Twin Cities, Duluth, Stillwater and Fergus Falls.

Extension Courses at Columbia

Two evening courses, one on medical terminology and the other on medical records, are being offered by the extension department of Columbia University, New York. The class in medical terminology is designed for those engaged in medical work who have had no previous scientific training that would acquaint them with correct terminology. The course in medical records appeals chiefly to those already in hospital record work who wish to familiarize themselves with approved practices and current developments in this field. It is based upon the system used at the Columbia-Presbyterian Medical Center.

Ninetieth Anniversary Celebrated

The ninetieth anniversary of the founding of the Passavant Hospital, Pittsburgh, was observed on July 17. The institution is the first Protestant church hospital established in America. The anniversary was celebrated with special exercises and the commencement of the graduating class. The Rev. H. L. Fritschel, D.D., superintendent of the Milwaukee Hospital, Milwaukee, delivered the anniversary address.

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Every hospital will agree that it wants fine surgical instruments, but fine instruments will not be supplied unless they are demanded.

To specify exactly what make of surgical instruments is desired is the only way to get fine quality-instruments.

To call for price on surgical instruments, without specification of maker, will bring prices on the cheapest instruments.

The seller will offer no better quality than the buyer calls for.

THE LOWEST BIDDER SUPPLIES THE CHEAPEST INSTRUMENTS.

No hospital can boast of its surgical instruments if they were bought without specification of maker.

Specify the maker so as to be sure of the quality that truly represents the hospital.

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The Kny-Scheerer Corporation was taken over by the United States Government, and sold by the alien property custodian in 1919 to Americans, and has so remained. The staff is composed entirely of Americans, and is conscientiously devoted to the one purpose of serving our industry in America.

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It was necessary for us to move in order to serve you better. So, we moved. Now, in even finer quarters, we can enlarge our staff; we shall have more room for our records of people and of hospitals; and we can assign new and modern conference rooms to our clients where they and you can ask us questions in perfect privacy.

You will like our new advantages, we feel sure, for if you seek a position as a physician, a hospital administrator, a graduate

nurse, a dietitian or a technician . . . we know we can help in more satisfying fashion than ever before.

Or, if conditions are reversed, if *you need* an employe, or *groups* of employes, if you want *uncommon* people with that earnestness and intent, understanding and integrity that *gets things done* . . . we intend to satisfy *your* needs, too, better than ever before.

So, if you ask for a position, or if you have positions to give, to fill, write to us. It is our great business: to find the job you would love; or, to find the finest, the smartest personnel in the land. Write us at our new address.

Our booth, at the meeting of the American Hospital Association in
Toronto, is No. 17. Won't you call on us there?

The MEDICAL BUREAU

919 North Michigan Ave., Palmolive Building
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CHICAGO, ILLINOIS

Names in the News

Administrators

FRED G. P. LATTNER, formerly administrator of the Finley Hospital, Dubuque, Iowa, has been appointed executive director of Hospital Service, Inc., of Iowa, Des Moines. Mr. Lattner has been administrator of the Finley Hospital since 1930. He served as president of the Iowa Hospital Association in 1937 and 1938.

DR. ROY W. WRIGHT, who for many years has been associate director of the Charity Hospital, New Orleans, has been appointed director of the institution, succeeding Dr. GEORGE S. BEL who died recently. In his capacity as head of the hospital, Doctor Wright will have the responsibility of equipping and opening the new eight million dollar structure that is now nearing completion.

EVA JENSON, R.N., for the last three years superintendent of the Lexington Community Hospital, Lexington, Neb., has resigned that position. GERTRUDE SESSION, R.N., has been appointed to succeed her.

PAUL FESLER has been named business manager of Nopeming Sanatorium, Nopeming, Minn., succeeding GEORGE C. CONROY, who has held the position for the last twenty-four years. Mr. Fesler resigned the superintendency of the Minnesota State Sanatorium, Ah-Gwah-Ching, Minn., to accept the appointment.

SISTER MARY ROSE MIRIAM, superintendent of St. Joseph's Hospital, Elmira, N. Y., since the death of SISTER ROSE ALICE CONWAY on May 1, has been elected the Rev. Mother Superior of the Congregation of Sisters of St. Joseph, the largest sisterhood in the Rochester Roman Catholic Diocese. Her successor as superintendent of St. Joseph's Hospital will be chosen within a short time.

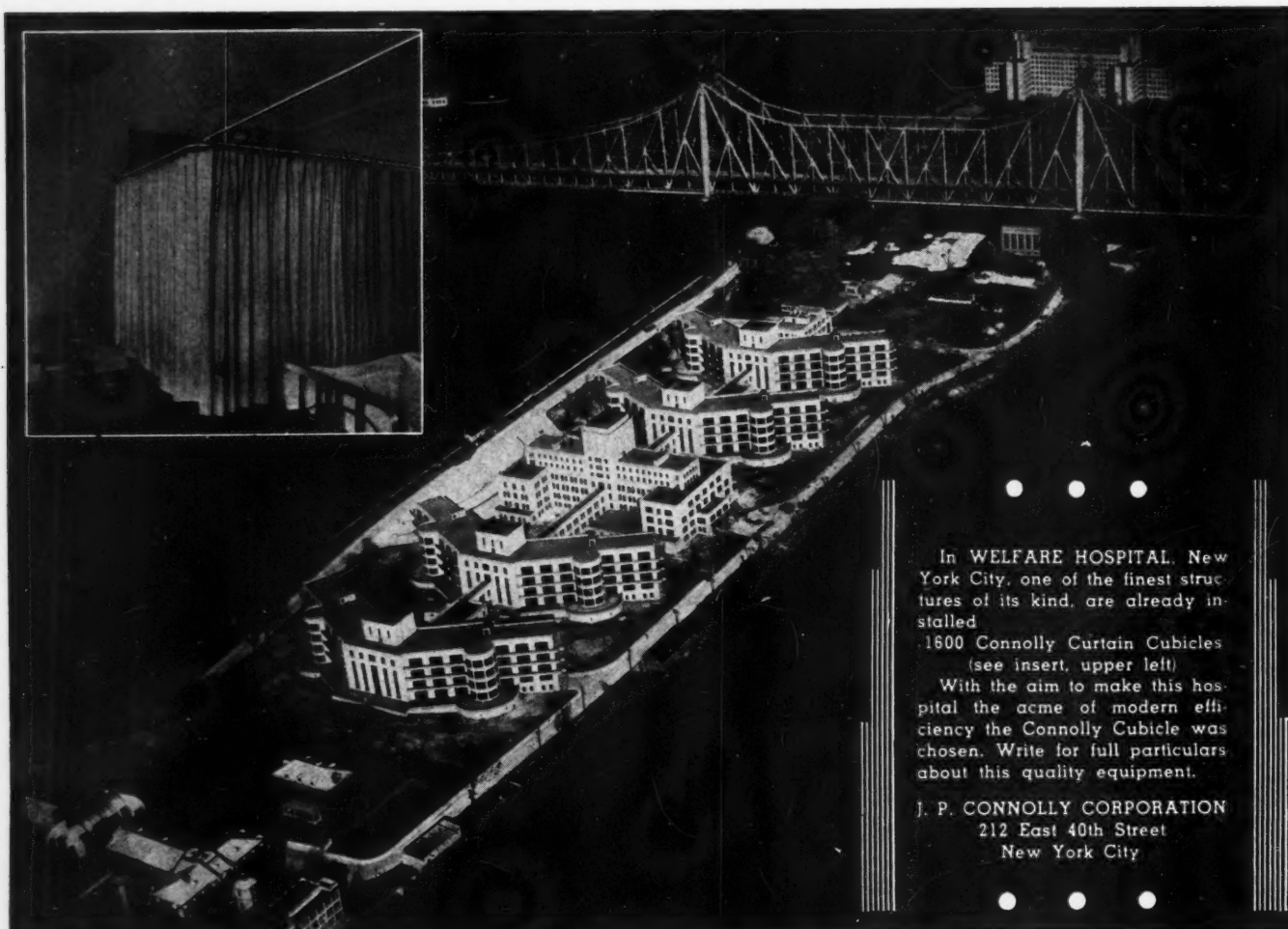
DR. G. W. BRUGLER, who recently joined the staff of the University Hospitals of Cleveland as assistant to the director, has been appointed assistant director of the institution. GLEN E. CLASEN has also been named an assistant director.

DR. CURTIS H. LOHR, administrator of the St. Louis County Hospital, Clayton, Mo., was elected president of the St. Louis Hospital Council at the annual meeting of the association. Other officers elected included: SISTER ALPHONSINE, administrator, De Paul Hospital, vice president; ESTELLE D. CLAIBORNE, R.N., superintendent, St. Louis Children's Hospital, secretary, and MRS. MARY J. KEITH, R.N., superintendent, St. Louis Maternity Hospital, treasurer.

COL. HUGH SCOTT, administrator of the Veterans' Administration Hospital, Hines, Ill., has been relieved from duty effective September 1. COLONEL SCOTT has been in charge of the hospital since 1927. Prior to that appointment he served as assistant surgeon general of the U. S. Public Health Service in Arkansas.

DR. THEODORE A. WOLLOCK, who has been head of the Torrance State Hospital, Torrance, Pa., since 1936, has submitted his resignation to the board of trustees.

DR. HARRY J. BRAYTON, superintendent of the Onondaga Sanatorium, Syracuse, N. Y., has resigned that position because of ill health.

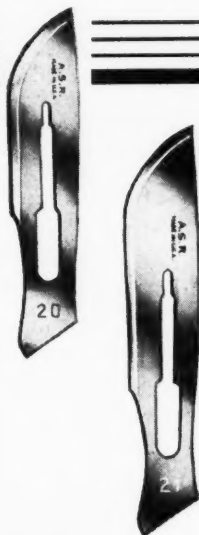


In WELFARE HOSPITAL, New York City, one of the finest structures of its kind, are already installed
1600 Connolly Curtain Cubicles (see insert, upper left)

With the aim to make this hospital the acme of modern efficiency the Connolly Cubicle was chosen. Write for full particulars about this quality equipment.

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The knowledge gathered from nearly forty years of experience with precision edges is reflected in the uniformity, keenness and quality of A. S. R. Surgeon's Blades. They are suited exactly to the surgeon's requirements and perform unflinchingly in his hand. They are the product of exhaustive research and experiment. A. S. R. Surgeon's Blades are available in 9 standard types.

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SURGEON'S BLADES

and Handles

BENNETT J. MCCARTHY has been appointed business manager of the Winchester Memorial Hospital, Winchester, Va.

DR. MERLE D. BONNER, superintendent and medical director of the Guilford County Tuberculosis Sanatorium, Jamestown, N. C., was honored at a dinner held by the Guilford County Medical Society on August 3. Tribute was paid to Doctor Bonner for his outstanding work both in medicine as a member of the county medical society and in directing the hospital.

E. L. FARRELL has been appointed assistant superintendent of St. Luke's Hospital, Kansas City, Mo. He will be in charge of building and power plant practice and building maintenance.

Trustees

DENIS T. NOONAN was reelected president of Hillcrest Hospital, Pittsfield, Mass, at the annual meeting of the hospital corporation. Other officers elected were: Carl B. Lindholm, vice president; E. J. Cowlin, secretary, and Dr. William T. Tracy, treasurer.

Department Heads

MRS. JOSEPHINE H. COMBS, R.N., will retire on September 15 from her position as director of nurses of the Woman's Hospital, New York City. She has been head of the department for the last nineteen years. The board of governors of the hospital has granted her an annuity for life in appreciation of her services. Mrs. Combs will be succeeded by GRACE E. HAYCOCK, R.N.

MARION SMITH, R.N., has been named assistant superintendent of nurses and anesthetist at the Southeast Missouri Hospital, Cape Girardeau, Mo. Prior to this appointment, she was associated with Jewish Hospital, Philadelphia.

E. LOUISE GRANT has been appointed dean of the school of nursing of the Medical College of Virginia, Richmond, succeeding FRANCES HELEN ZEIGLER, who resigned last year to accept the deanship of the school of nursing at Vanderbilt University, Nashville, Tenn. Miss Grant was formerly associated with Temple University School of Nursing, Philadelphia.

DR. JUAN M. JIMENEZ has been made director of the radiologic department of Paterson General Hospital, Paterson, N. J. Doctor Jimenez has for many years been active in the field of radiology both in this country and in South America.

Deaths

TEAGUE JENNINGS, a salesman for Meinecke and Company, New York, died in Norfolk, Va., on July 25 after being beaten by two unidentified men in soldiers' uniforms. Police have been unable to account for the attack.

MORRIS WEISS, night superintendent of the Jewish Hospital, Brooklyn, N. Y., died July 21 after a long illness. Mr. Weiss had been associated with the hospital for twenty-two years, having started as hall boy.

Miscellaneous

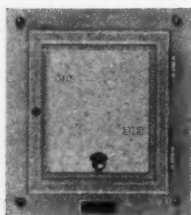
DR. DONALD A. R. MORRISON has joined the medical staff of the Rogers Memorial Sanitarium, Oconomowoc, Wis. For the last two years Doctor Morrison has been an instructor in the psychiatry department at the University of Chicago Medical School.

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A

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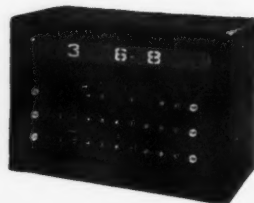
Simple, effective, practically fool-proof. Special call button in indestructible case flashes light in corridor, duty station and annunciator. If this doesn't get attention, patient presses button further, thus sounding buzzer. Saves time, trouble and delay.



B

Doctors Paging System

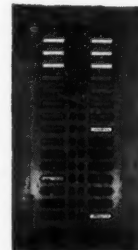
Gives you a quick, quiet, efficient way to call any Doctor in the hospital. Three doctors may be called at one time on the "Standard" Doctors Paging System.



C

Doctors In and Out Register

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New Zealand Health Plan Opposed

The health sections of the social security act of New Zealand, which were scheduled to go into effect along with the other parts of the act on April 1, have not yet been put into operation because of opposition from the New Zealand branch of the British Medical Association and because of the large amount of preparatory organization that is necessary on the part of the government. The government plan is designed to provide universal benefits, including doctors' service, prescriptions, hospital and maternity care.

Appeal A.M.A. Monopoly Suit

The United States Department of Justice asked the court of appeals on July 31 to overrule a lower court decision that the American Medical Association could not be prosecuted on charges of violating the Sherman Anti-Trust Act.

Fire Cuts Off Power in Two Hospitals

A short circuit and fire in a substation cut off the power at Elizabeth, N. J., for sixteen minutes recently while two operations were in progress at St. Elizabeth's Hospital and one at Alexian Brothers' Hospital.

New A.C.H.A. Members*(Continued from page 71)*

Gonzales, Sister M., Mercy Hospital, Springfield, Mass.
 Hamner, Mae L., Johnston-Willis Hospital, Richmond, Va.
 Hiebert, Dr. Joelle C., Central Maine General Hospital, Lewiston, Me.
 Hunt, C. E., Lubbock Sanitarium, Lubbock, Tex.
 Joseph, Sister M. (Sullivan), St. Mary's Hospital, Port Arthur, Tex.
 Jovita, Sister Mary, St. Margaret's Hospital, Antigonish, N. S.
 Knowlton, Dr. W. W., Boston Lying-In Hospital, Boston.
 Korsell, Mabel M., Itasca Hospital, Grand Rapids, Minn.
 Leonard, Sister Mary, St. Mary's Hospital, San Francisco.
 Lidwinna, Sister Mary (Zens), Mercy Hospital, Chicago.
 Ligouri, Sister M., St. Lukes Hospital, Pasadena, Calif.
 Loreto, Sister Mary, St. Vincent Hospital, Worcester, Mass.
 Louise, Sister (McParland), Emergency Hospital, Buffalo, N. Y.
 MacFadden, Shannah, Leominster Hospital, Leominster, Mass.
 Marcelline, Sister Mary, St. Mary's Hospital, Madison, Wis.
 Margaret, Sister (Callahan), St. Joseph's Hospital, Alton, Ill.
 Margaret, Sister Stella, Holy Family Hospital, Brooklyn, N. Y.

Mary, Sister Margaret (Kane), St. Joseph Mercy Hospital, Sioux City, Iowa.
 McAhren, Myrtle A., Blessing Hospital, Quincy, Ill.
 Miller, Elizabeth, Paul Kimball Hospital, Lakewood, N. J.
 Monica, Sister Mary, St. Joseph's Hospital, Phoenix, Ariz.
 Mortensen, Dr. William S., Santa Monica Hospital, Santa Monica, Calif.
 Muench, Dr. Carl E., Crouse-Irving Hospital, Syracuse, N. Y.
 Nadell, Dr. Bernard B., Bellevue Hospital, New York.
 Patterson, Hamilton V., Hurley Hospital, Flint, Mich.
 Peck, Dr. John H., State Sanatorium, Oakdale, Iowa.
 Pellenz, Dorothy, Crouse-Irving Hospital, Syracuse, N. Y.
 Petronella, Sister M. (Farrell), St. Joseph Mercy Hospital, Fort Dodge, Iowa.
 Phelps, Grace, Doernbecher Memorial Hospital, Portland, Ore.
 Porter, F. Ross, Duke University Hospital, Durham, N. C.
 Prudentia, Sister M. (Blake), Mercy Hospital, Janesville, Wis.
 Regina, Sister Alice (McCarthy), St. Elizabeth Hospital, Elizabeth, N. J.
 Regina, Sister Mary (McNamara), Mercy Hospital, Bay City, Mich.
 Rich, William N., Lincoln Hospital, Durham, N. C.
 Rowlands, Edward, Wesley Memorial Hospital, Chicago.
 Schenkweiler, Louis, Wyckoff Heights Hospital, Brooklyn, N. Y.
 Seraphine, Sister M. (Kane), St. Francis Hospital, Port Jervis, N. Y.

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 Stanislaus, Sister M. (Carey), St. Joseph Mercy Hospital, Sioux City, Iowa.
 Syrkin, Dr. E. E., Beth Moses Hospital, Brooklyn, N. Y.
 Taylor, Dr. Lewis H., Sibley Memorial Hospital, Washington, D. C.
 Teresa, Sister (Kelly), St. Mary's Hospital, Evansville, Ind.
 Thomas, Sister Mary, St. Joseph's Hospital, Phoenix, Ariz.
 Trimble, Louis C., Adrian Hospital, Punxsutawney, Pa.
 Vincentiana, Sister M. (Traffas), St. Francis Hospital, Beech Grove, Ind.
 Walters, Fred M., Memorial Hospital, Houston, Tex.
 Walters, Nick, Lewis-Gale Hospital, Roanoke, Va.
 Weiss, Harvey H., Memorial Hospital, Cumberland, Md.
 Wessels, Dr. George L., Allegheny General Hospital, Pittsburgh.
 Whittington, James B., City Hospital, Winston-Salem, N. C.
 Wilhelm, Dr. Norbert A., Peter Bent Brigham Hospital, Boston.
 Williams, Gerald S., Children's Hospital of Winnipeg, Winnipeg, Man.
 Winston, Marcellus E., Rex Hospital, Raleigh, N. C.

Elected to Junior Membership

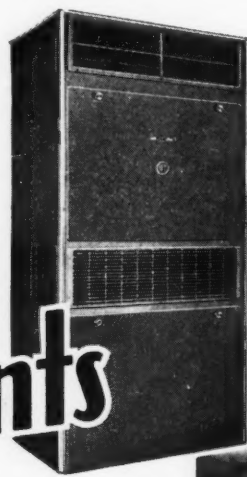
Bayne, Gladys, United Hospital, Port Chester, N. Y.
 Bath, Francis J., Creighton Memorial, St. Joseph's Hospital, Omaha, Neb.
 Beatrice, Sister Mary, St. Michael's General Hospital, Lethbridge, Alta.

Berenice, Sister (Forest), Lewis Memorial Maternity Hospital, Chicago.
 Britt, Margaret E., Hudson City Hospital, Hudson, N. Y.
 Burr, H. B., City Hospital, Akron, Ohio.
 Camillus, Sister Mary (Jorae), Mercy Hospital, Jackson, Mich.
 Carlson, Wendell H., Augustana Hospital, Chicago.
 Chadbourn, Lloyd H., c/o Duke Endowment, Charlotte, N. C.
 David, Sister Mary (Reedy), St. Joseph's Riverside Hospital, Warren, Ohio.
 Davidson, Edna G., Black Hills Methodist Hospital, Warren, Ohio.
 Eckert, Kingsley A., University of Iowa Hospitals, Iowa City, Iowa.
 Flaviana, Sister Mary (Schmalz), St. James Hospital, Chicago Heights, Ill.
 Florence, Agnes F., Dixon Public Hospital, Dixon, Ill.
 Gerhardis, Sister Mary (Weyer), St. Anthony Hospital, Michigan City, Ind.
 Gloman, Robert W., Wyoming Valley Homeopathic Hospital, Wilkes-Barre, Pa.
 Grahn, Lillian, Free Hospital for Women, Brookline, Mass.
 Groner, F. S. Jr., Southern Baptist Hospital, New Orleans.
 Hall, Katherine, Wentworth Hospital, Dover, N. H.
 Hromadka, Ralph, Santa Monica Hospital, Santa Monica, Calif.
 King, Dorothy, Methodist Hospital, Princeton, Ind.
 Kniffen, Robert C., New York Hospital.
 Lindberg, Victor S., Victory Memorial Hospital, Waukegan, Ill.
 Magdalen, Sister M. (Devereaux), Mercy Hospital, Jackson, Mich.

Martin, Helen G., Ohio Valley Hospital, Steubenville, Ohio.
 Martina, Sister Mary (Coyle), Mercy Hospital, Scranton, Pa.
 Mickey, Harold C., Duke Hospital, Durham, N. C.
 Miller, Henrietta, Children's Orthopedic Hospital, Seattle, Wash.
 Mongeau, Mary, Webster District Hospital, Webster, Mass.
 Murray, Beatrice V., Mary Lane Hospital, Ware, Mass.
 Rita, Sister (Coyle), St. Vincent's Hospital, Philadelphia.
 Roberts, Norman B., Hinsdale Hospital and Sanitarium, Hinsdale, Ill.
 Robertson, Marie, San Pedro Hospital, San Pedro, Calif.
 Rosa, Sister, Providence Hospital, Washington, D. C.
 Rosenberger, Donald M., Clearfield Hospital, Clearfield, Pa.
 Ross, Helen B., Community Hospital, Kane, Pa.
 Samuela, Sister M. (Yonker), St. Mary's Hospital, Gallup, N. M.
 Scott, Roland Albert, Grant Hospital, Chicago.
 Snoke, Dr. Albert W., Strong Memorial Hospital, Rochester, N. Y.
 Stimson, Russell H., Huron Road Hospital, Cleveland.
 Swain, Frank G., Santa Monica Hospital, Santa Monica, Calif.
 Thode, Martina C., Public Hospital, Sterling, Ill.
 Weedon, Fanning H., Mary Black Memorial Hospital, Spartanburg, S. C.
 Young, Kathleen, New Rochelle Hospital, New Rochelle, N. Y.

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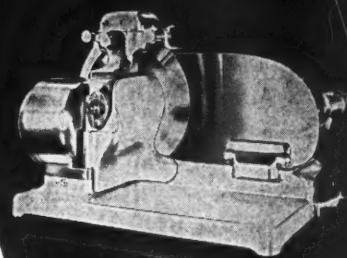
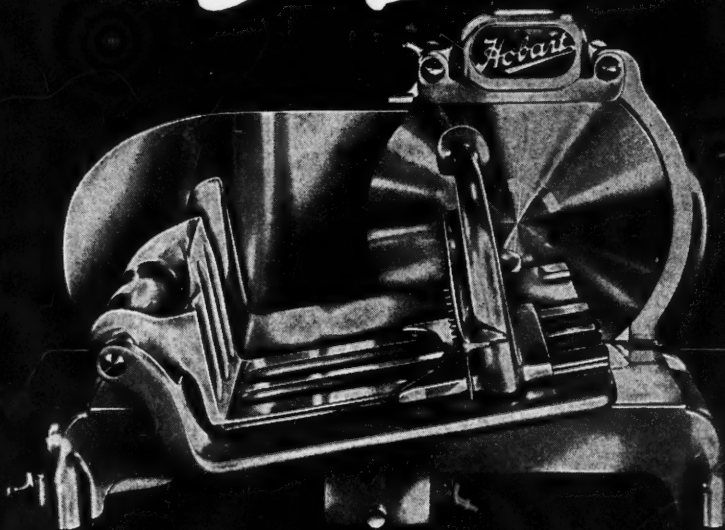
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Add to this the new TRIPLE-GRIP... the Adjustable-ANGLE GRIPPER PLATE for popular "bias cuts"... the Solid Stainless Steel Staysharp Knife... the beautiful silvery FINISH and other features—no wonder they call this an UNEQUALLED practical Kitchen Machine! Send coupon today.

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BOOKS ON REVIEW . . .

SPORTS FOR THE HANDICAPPED. By George T. Stafford, Ed.D. New York: Prentice Hall, Inc., 1939. Pp. 302. Trade: \$2.75; Text: \$2.

If one lesson is taught in this volume, it is that discouragement has no place in handling this group of a million crippled children and adults in the United States. The author stresses the necessity for a careful physical evaluation of the degree of handicap and a thorough psychologic study of its effect on the personality of the patient himself. Of specific interest and help are the 175 pages devoted to the adaptation of treatment to the many types of congenital and acquired physical defects. This volume is a splendid addition to a hitherto little explored field.—J. C. DOANE, M.D.

FOOD FOR FIFTY. By Sina Faye Fowler and Bessie Brooks West. New York: John Wiley and Sons, Inc., 1937. Pp. 384. \$3.

This book gives formulas for the foods that make up the menus in the average institution; all have been tested and in many instances the basic formulas are augmented by suggestions for variations.

Especially valuable are the tables of temperatures used for various cookery processes; equivalent weights and measures, which are very inclusive, and approximate amounts of food required to serve 50 persons. The chapters on meat, poultry, fish, salads and sandwiches give information on buying and methods of preparation in addition to recipes.—INEZ SEARLES WILLSON.

SULFANILAMIDE THERAPY OF BACTERIAL INFECTIONS. By R. R. Mellon, M.D., and F. B. Cooper, M.S., Institute of Pathology, Western Pennsylvania Hospital, Springfield, Ill., and Baltimore, Md.: Charles C. Thomas, 1938. Pp. 398. \$4.

No more than three years have elapsed since the introduction of sulfonamide compounds into the therapeutics of bacterial infections and scarcely more than two years since the first reports of their clinical use in America.

The startlingly efficacious results from the use of some of these compounds in the treatment of certain acute infections led to their widespread adoption with unusual rapidity. The insufficiency of pharmacologic background, which ac-

companied that adoption, is being reduced. Serious toxic reactions (fortunately relatively few in number) are being brought to light, and investigation of the mode of action of the drugs has made some progress. Related compounds are being developed and subjected to trial.

No review, unless constantly reedited, could keep pace with the advance of a subject as active as this one. The appearance since this book went to press of reports of the greater efficacy of sulfapyridine in pneumococcal infections is a good illustration. Because of the inadequacy of pertinent literature, portions of the book dealing with the treatment of infections of man are in many respects wanting. The results of the treatment of certain streptococcal, and perhaps meningococcal, infections are convincing.

Most of the data on the treatment of other infections are too meagre and too inadequately controlled. Some of the most informative chapters have to do with the authors' own investigations of the effect of sulfanilamide on streptococci and pneumococci in vitro and in a variety of animal hosts. It is to be hoped that extension of our knowledge of the sulfonamides will prompt future editions of this useful work.—HOWARD B. SLAVIN, M.D.

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DESIGNED by Dr. Ferris Smith, one of the country's leading skin grafting specialists. Plastic surgeons recognize that this new instrument is far superior to any that they have known or used in the past. The cutting edge is finished like a microtome knife, which is the finest edge obtainable. This superior cutting edge makes it possible to cut grafts of more uniform thickness and with greater ease. The blades are replaceable, and the convenience of having a sharp blade at hand at all times will be readily appreciated by surgeons. Skin graft knives with fixed blades must be returned to the instrument maker frequently for resharpening. This necessitates the purchase of a number of complete knives and the frequent annoyance of finding that knives sharp enough to use are not available.

Made in two sizes: to hold 6" blades and 4" blades. The varying length of the blades makes for greater convenience and economy. The great majority of grafts can be cut with the short blade. Larger grafts will require the longer blade. Write for prices on the different combinations.

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Large 6" blades—holder and set of 6 blades in box, \$18.00 Set

Dr. C. R. Straatsma says:

"It is the finest thing I have ever used. I used my retractors for tension and your knife for cutting the split grafts. One graft measured 3" x 6", another 2½" x 6" and the third was 4" square."



Acknowledgment is made of the special cooperation given by Dr. James T. Mills, F.A.C.S., of Dallas, Texas, in the designing of this new model.





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Headed by scientists who are recognized authorities in their fields, Spencer's Research Department is engaged constantly upon the task of improving established optical instruments and designing new equipment to extend present scientific work.

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Spencer Medical Microscopes, the choice of thousands of physicians, are suited for the most critical work or for routine laboratory tests.

Spencer "Bright-Line" Haemocytometers increase accuracy and decrease eye strain in making blood counts. This is accomplished by bright lines on a dark background instead of the conventional gray lines on a light background.

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Spencer Dark Field Microscopes represent the most recent Spencer microscope development. They save considerable time in routine dark field work.

Spencer Quebec Colony Counters with their dark field and bright lines improve the visibility of colonies, assuring quicker, more accurate colony counts.

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RELAXATIVES

HOSPITAL MOTHER GOOSE

- Jack and Jill drove down the hill
Much faster than they oughter.
They hit a tree and broke Jill's knee.
To the hospital they brought her.

Around Jack hovered 'till Jill re-
covered,
And promised us the cash.
The hospital bill is unpaid still
But Jack has a brand new Nash.

Theme Songs for Hospital People

- SUPERINTENDENT: "No, No, a Thou-
sand Times No!"
- SOCIAL SERVICE WORKER: "Nobody
Knows the Trouble I've Seen"
- DIETITIAN: "Yes, We Have No
Bananas"
- ANESTHETIST: "Good Night, Sweet-
heart"
- DISCHARGED PATIENT: "There's No
Place Like Home"
- RESIDENT STAFF: "The Stein Song"
- CASHIER: "I Can't Give You Any-
thing But Love, Baby"

Three Cheers for Gray, Green and Blue

- New York.—Nature's main colors—
blue of the sky, gray of the mists, green
of the trees—are best for operating
rooms because they save surgeons' eyes
from strain, Dr. William Henry Walsh
of Chicago told the International Col-
lege of Surgeons here today. Even the
sheets and drapes over the patient
should be so colored, he said.

When the nurse's blue eye meets the
surgeon's gray head
And the green interns run all around,
It's fine to remember the things that
are said
About keeping one's feet on the
ground.

Which Flowers Belong in Hospital Beds?

- The salvia dripped gay color against
the garden fence and the filariasis and
the fritillaria made a new effect in
borders. The Japanese beetle had
ruined the verruca and the veronica
but the heliopsis and the pulmonaria

grew so sturdily that the seborrhea was
almost hidden. We were amazed at
the success of the hepatitis and next
year will use it instead of the old fash-
ioned hepatica. The physostegia and
the rubella never bloomed but the
bleeding heart and the sanguinaria
were the brightest that I have ever
seen.

The gardener said the cool damp
summer accounted for the small growth
of the syringoma but the variola and
the viola love such climatic conditions
and their blossoms were thickly scat-
tered.

Signs of the Times!

(Spotted in the waiting room of St.
Joseph's Hospital, Milwaukee, by
G.H.)

God bless our critics
Quiet! Our guests are ill.

Fish Story

- The goldfish swallowing contests
among college boys had their effect
on one of the typists in a New York
hospital. She transcribed a letter with
the final line as follows:

"The patient was discharged on
dilute hydrochloric acid to take 10
minnows three times a day in water
with meals."

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paneling. Actually case hardens the surface, there-
fore stands hardest kind of traffic wear, without
showing the usual worn spots or lanes. Floors treated
with CHEKIT, if properly maintained with wax, never
have to be resanded.

✓ CHEKIT SUPER FINISH

—a tough, bakelite varnish that gives outstanding
results on gymnasium floors, bar tops, any wood sur-
face that receives unusual abuse. Withstands alcohol
stains, rubber burns, alkalis, etc.

✓ CHEKIT WOOD FLOOR WAX

—a revolutionary, new self-polishing wax that con-
tains double the usual wax content. Water resistant.
Non-slippery. Made especially for use on wood floors
that have been treated with a Penetrating Seal.

For complete information on the "CHEKIT" line for
wood floors, see our ad in Sweet's Catalog or write
us direct.

The proper method of floor treatment
and maintenance, using these approved
finishes, will assure the utmost in appear-
ance, durability and safety—at the lowest
possible cost.

(For future maintenance, use RUBBER
GLOSS "aerated" WAX—it, too, carries
the approval of practically all nationally
known manufacturers of floor coverings.)

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**HOSPITAL EXECUTIVES THE WORLD OVER,
DECLARE HANOVIA EQUIPMENT—THE BEST!**

① HANOVIA SUPER 'S' ALPINE LAMP

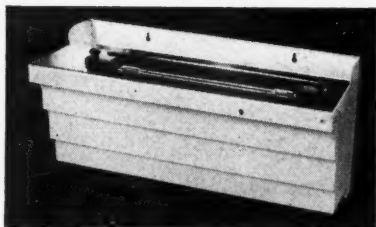
This lamp—foremost in the field of ultraviolet generators—is built for long and useful life and contains many outstanding features . . . It is a high pressure high intensity quartz mercury arc lamp . . . Starts instantly at the snap of the switch . . . Fast acting—enabling treatment of more patients in less time . . . Ten stages of intensity regulation by unique control . . . At 30 inches from the burner the intensity may be varied from 1,800 to 2,900 microwatts per sq. cm. Ammeter readings provide accurate control of dosage . . . Long burner life—exceptional economy—improved manipulative convenience . . . Adjustment of treatment distance is available up to 40" above standard cot.

② HANOVIA ULTRA SHORT WAVE UNIT

A simplified and convenient method of producing heat—deep within the tissues. Ideal for hospital use. Contains many outstanding features of which here are a few . . . Resonance tuning by single knob control . . . Pre-determined dosage limitation (dosage varies less than 10% with the variation in electrode size) . . . Foolproof plate and filament current switches protect oscillator tubes . . . Ruggedly designed . . . Noiseless . . . No cooling necessary . . . Table terminals bolted to eliminate uncertainty of soldered connections . . . Line voltage compensator for maintenance of proper constant potential upon the plate, grid, and filament of the tube, regardless of changes in supply line voltage . . . All component parts specially designed and manufactured for medical work . . . Inductance cable . . . Nine step auto-transformer control for regulating energy supply to patient.

③ HANOVIA SOLLUX RADIANT HEAT LAMP

A therapeutic radiant heat lamp provided with either a 1,000 watt incandescent bulb element or a 1,200 watt glowing wire type infrared element. Well ventilated hood may be used in any position, either vertical or horizontal. Equipped with a terraced aluminum reflector providing an especially uniform field with no hot spots . . . This lamp is ideally suited for hospital use. Easily moved from one room to another. Simple and efficient in operation.



HANOVIA SAFE-T-AIRE QUARTZ ULTRAVIOLET LAMPS . . . FOR AIR SANITATION

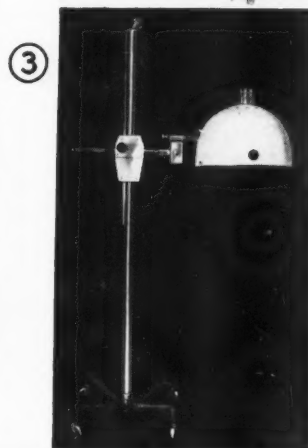
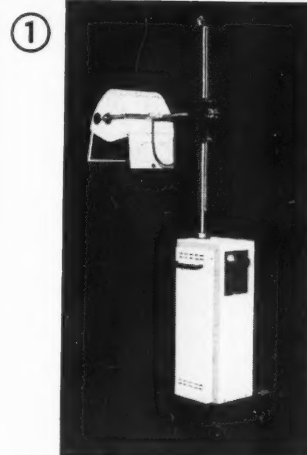
Especially designed for wide field of application in hospitals: operating rooms, milk formula rooms, nurseries, clinics, isolation wards, corridors and everywhere, where air sanitation is an important factor . . . Lamp illustrated is the wall bracket type.

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READER OPINION

Pharmacy Machines

Sirs:

I have read the article, "Pharmacy Safeguards," in the June number of *The Modern Hospital*. I have found this very interesting and wish to congratulate Montefiore Hospital on the efficient manner in which its pharmacy is conducted.

I notice the reference to an automatic power driven tablet machine and a power driven ointment mill. I should greatly appreciate it if you will send me the names of the manufacturers of these machines.

This college has a course in hospital pharmacy and we are desirous of making our students acquainted with the various kinds of equipment that should be used in a good hospital dispensary.

Edward H. Niles,
Dean.

Indianapolis College of Pharmacy,
Indianapolis, Ind.

• The ointment machine is described in Remington's "Practice of Pharmacy," page 1757. A tablet machine is also described in this textbook, pp. 1716 and

1717. The tablet machine in use at Montefiore Hospital was originally hand driven but was later converted by the engineering department to a power driven machine. It does not appear in the illustration of the article. The machine shown in the illustration is a lozenge machine, which is not power driven. It was planned and made in the hospital machine shop.—Ed.

I. H. A. Program

Sirs:

You could not have rendered the International Hospital Association and its president a greater service than the splendid way in which you set up the program of the Congress in the August issue of *The Modern Hospital*. I certainly cannot thank you enough for the space you have given to this program. I am confident that it will mean a renewed interest in the association at this time and a much larger attendance from the United States and Canada.

Ever since the inception of *The Modern Hospital*, I have recognized its real value to the hospital field and again

I say what I have said a thousand times: It has done more in raising the standards of our hospitals than any other means of this kind, and it has done silently a work that is comparable to that which the various associations have done in more spectacular ways.

I thank you again for this splendid exposition of the International Hospital Association Congress.

Malcolm T. MacEachern, M.D.,
President.

International Hospital Association.

Distorted Picture of Hospitals

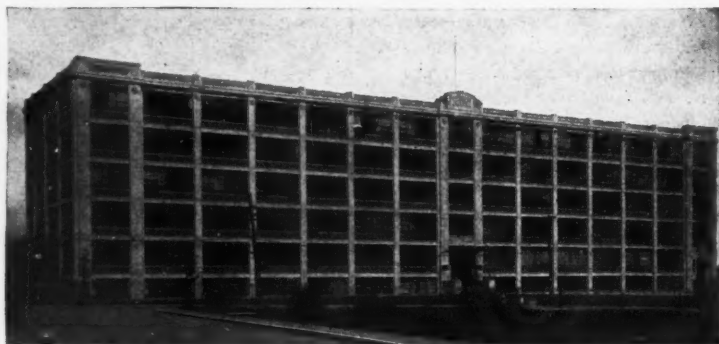
Sirs:

I have read the proofs of "The Hospital" by Kenneth Fearing. [Published by Random House on August 29—Ed.] The book presents a venomously distorted picture of hospital practice. The writer makes no secret of his condemnation of the existing social order and this, I suppose, accounts for his morbid characterizations of hospital trustees, hospital contributors, physicians and nurses.

The author must have led a very bitter life for he seems to have nothing but hatred and contempt for mankind.

S. S. Goldwater, M.D.

Department of Hospitals,
New York City.



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Pioneers in the development and perfection of Hospital Signaling Equipment, the name HOLTZER-CABOT has for many years been recognized the outstanding leader in the field. Its contributions to greater efficiency have materially elevated the standards of service and lessened the labors of doctors and nurses in many of the foremost hospitals in the country. As a result—more hospitals have adopted Holtzer-Cabot Hospital Signaling Systems than all other makes combined! Our cumulative experience of 65 years is at your service.

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Accuracy in determining gastric contents depends to a considerable degree upon the alcohol used in the analysis. Laboratory technicians in hundreds of hospitals prefer U.S.I. ethyl alcohol because they have found it singularly free from toxic and organic impurities such as acidity, fusel oil, aldehydes and other foreign constituents. They have learned also to rely upon it not only for use in gastric analysis but for many other laboratory tests—tissue pathology, special dehydrating and staining techniques and similar exacting types of work.

U.S.I. alcohol complies with U.S.P. XI and N.F. VI standards but it is re-tested to conform to U.S.I.'s exceptionally rigid standards. That is why it is recognized as the *safe* alcohol to use for a variety of purposes throughout the hospital.

Let U.S.I.'s hundred years of experience in the hospital field help you in the selection of your alcohols. Ask our representative to give you the benefit of his special knowledge of hospital alcohol requirements.

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ALCOHOL

IT'S SAID THAT—

SCANLAN-MORRIS COMPANY, Madison, Wis., announces a water-fill and vent-o-stat device for supplying water to instrument sterilizers, which incorporates a nonmechanical method of preventing backsiphonage of the sterilizer's contents into the water supply lines. . . . The 1939 "Handbook of Building Maintenance," which discusses the care of floors and roofs, has been made available by the FLEXROCK COMPANY, Philadelphia. . . . Six "Sunkist Food Lessons," (1939 series) containing information on the dietetic and health value of citrus fruits are being offered by the CALIFORNIA FRUIT GROWERS EXCHANGE, Los Angeles.

A new line of lower priced sectional bake ovens has been announced by the STANDARD GAS EQUIPMENT CORPORATION, 18 East Forty-First Street, New York. The ovens are equipped with a multiple heat conduit system to assure even distribution of heat and with a burner system that adds speed and efficiency.

The ARMSTRONG CORK COMPANY, Lancaster, Pa., has made available an interesting folder on the problem of reducing noise and improving hearing conditions in all types of buildings.

A popular priced rubber flooring, identified as "Wingfoot," has recently been announced by the GOODYEAR TIRE & RUBBER COMPANY, Akron, Ohio. The floor covering is available in seven colors and is applied to the floor in the same manner as is linoleum. . . . "Rodite," an effective raticide that has been developed by the WEST DISINFECTING COMPANY, Long Island City, N. Y., is simple to use, economical and relatively harmless to human beings and to animals other than rats and mice.

Three new germicidal lamps have been announced by the GENERAL ELECTRIC COMPANY, Nela Park, Cleveland. Installed experimentally in air ducts, the new germicidal tubes have proved successful in killing airborne bacteria.

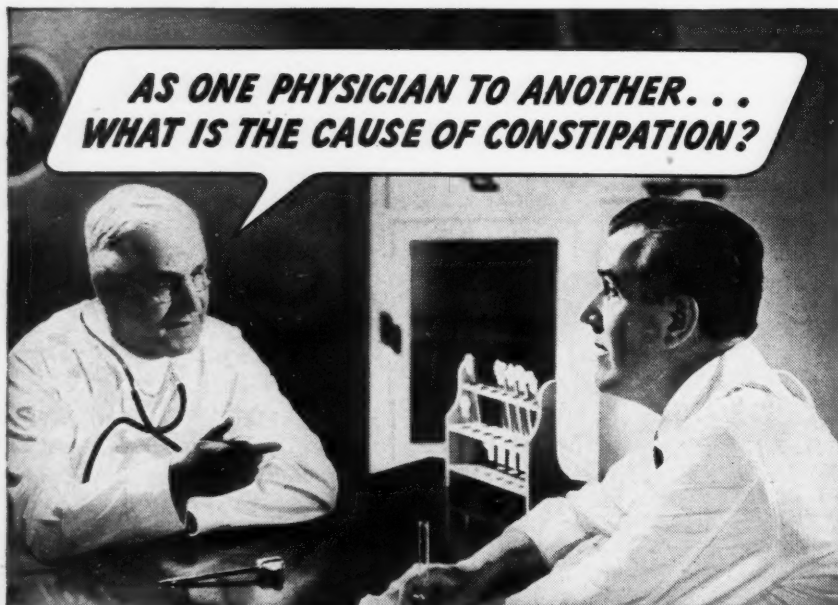
The Universal heating pad, manufactured by LANDERS, FRARY AND CLARK, New Britain, Conn., is an

innovation in this type of equipment because it is thermostatically controlled so that its heat production may be adapted to individual circumstances.

A handsome 48 page "Sanitation Handbook," published by the HUNTINGTON LABORATORIES, INC., Huntington, Ind., describes and illustrates all of the Huntington products.

The IROQUOIS CHINA COMPANY, Syracuse, N. Y., has been reorganized. EARL CRANE has acquired the principal interest in the corporation and has assumed the position of vice president and general manager; CHARLES H. COBURN continues as president of the company, and R. C. COBURN has been named assistant general sales manager.

C. N. CAHILL has resigned from the AUTOPOINT COMPANY, Chicago, to become president and general manager of the CHICAGO VENETIAN BLIND COMPANY. . . . WAYNE MENDELL has been placed in charge of sales of the TROY LAUNDRY MACHINERY division of AMERICAN MACHINE AND METALS, INC., East Moline, Ill.



OBVIOUSLY, there is no single cause. Each case must be judged on its own merits. Anatomical differences, variations in diet and habit and specific pathological entities all enter into the cause. However, it is safe to say that faulty habit plays a role in the great majority of cases, and that loss of neuro-muscular tone is a very common secondary factor.

To make habit training easier, a bland, pure mineral oil is important. To increase tonus of debilitated intestinal musculature and nervous system caused by Vitamin B-1 deficiency, pure crystalline Vitamin B-1 has been found to be of great value.

In *Vita Nujol*, these two important aids in the relief of constipation have been combined.

Vita Nujol is a smooth, pleasant-tasting emulsion of pure mineral oil with pure crystalline Vitamin B-1 added in such quantity that the suggested average dosage is the average adult maintenance dose of that important food factor (400 International Units).

Vita Nujol has a place in the treatment of the majority of constipation cases, and also in the gastro-intestinal syndromes of chronic alcoholism and many other pathological states associated with Vitamin B-1 deficiency.

Vita Nujol has been thoroughly tested and proven in laboratory and clinic.

A postal card will bring you free samples and descriptive literature. **Stanco Inc., 1 Park Avenue, New York, New York.**

VITA Nujol



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